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The New York Academy of Medicine.

By Publishers.

SEP 25 1915

FORTY-SECOND ANNUAL SESSION—DELAND—MAY 12-14, 1915

THE JOURNAL

—OF THE—

Florida Medical Association

OWNED AND PUBLISHED BY THE FLORIDA MEDICAL ASSOCIATION

VOLUME I
No. 1

Jacksonville, Florida, July, 1914

Yearly Subscription, \$1.00
Single Copy, 15c

CONTENTS

ORIGINAL ARTICLES

- Organized Medicine and Legislation, J. Harris
Pierpont, M. D., Pensacola..... 1
- The Karell-Kur. Thomas Truelsen, M. D.,
Tampa 3
- Diagnosis and Treatment of Venereal Ulcers.
Walter P. Dey, M. D., Jacksonville..... 6
- Sand-Spur in the Larynx—Its Removal, With
Report of Two Cases. Calvin D. Christ,
M. D., Orlando 9
- Propaganda for Reform 11

- Proceedings of the Forty-First Annual Meet-
ing of the Florida Medical Association... 11

EDITORIALS

- Announcement 22
- An Appeal for Medical Legislation..... 22
- Our Advertising Policy 23
- The Atlantic City Meeting..... 23

REVIEW OF CURRENT LITERATURE SURGERY

- Radium in Cancer 24
- Early Recognition of Cancer 24

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CONTENTS—Continued

REVIEW OF CURRENT LITERATURE—Con.

MEDICINE

Constipation and Its Treatment..... 25

GYNECOLOGY

Caesarean Section for Eclampsia..... 26

PEDIATRICS

Acid Intoxication in Infants 27

Studies in Cardiac Stimulants..... 27

Silver Nitrate Solution in the Treatment of
Whooping Cough 28Medical Aspects of the Treatment of Pyloric
Stenosis in Infants 28

DERMATOLOGY AND SYPHILOLOGY

Salicylic Acid and Zinc Oxide Plaster in the
Treatment of Small Skin Cancers..... 28Change of Climate and High Altitude in the
Treatment of Pellagra 29Attempted Cultures in a Case of Leprosy Un-
successful 29

External Vaccine Therapy 29

Injection of Concentrated Solutions of Salvar-
san and Neosalvarsan 29

Association News 30

News Items 30

New and Non-Official Remedies..... 32

INDEX TO ADVERTISEMENTS

Atlanta Medical College..... i
 Atkinson Tire and Supply Co..... vii
 Claude Nolan—Cadillac Motor Cars..... iv
 College of Medicine of Tulane University..... xv
 Dr. Morse's Sanatorium..... vi
 Drs. Petty and Wallace's Sanatorium..... vii
 Florida National Bank..... v
 Florida Life Insurance Company..... x
 Groover-Stewart Drug Co..... ii
 G. H. Sherman..... vii
 Hess & Slager..... ix
 Hotel Seminole..... xiii
 Imperial Garage—Saxon Motor Cars..... x
 James & Paxon..... x
 Jacksonville Gas Co..... vii
 Lexington-Howard Auto Co..... iii
 Mellin's Food..... xiv
 Medical College of the State of South Carolina..... xi
 Parke, Davis & Co..... last page
 St. Luke's Hospital—Dr. Stuart McGuire..... vi
 Stuart-Bernstein Co..... viii
 School of Medicine—University of Alabama..... xi
 Surgical Supply Co..... xi
 Sinkler-Price Co.—Hupmobile Auto Co..... xiii
 The Bond & Bours Co..... iv
 The Heard National Bank..... v
 The Atlantic National Bank..... v
 The C. V. Mosby Co..... viii
 The H. and W. Drew Co..... ix
 The Florida Tuberculosis Sanatorium..... xii
 The Bettes Pharmacy..... xiv

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

JACKSONVILLE, FLORIDA, JULY 18, 1914

Number 1

ORIGINAL ARTICLES

ORGANIZED MEDICINE AND LEGISLATION.*

J. HARRIS PIERPONT, M. D.,

Pensacola, Fla.

A full quarter of a century has passed since I was honored by membership in the Florida Medical Association, and enjoyed the fellowship of such devoted champions of organized medicine as Wall, of Tampa; Gary, of Ocala; Caldwell, of Sanford; Stringer, of Brooksville; Walker, of Cedar Keys; Sweeting, of Key West; the Mitchells, of Jacksonville, and our honored and late lamented secretary, Fernandez; all of whom have passed to the Great Beyond, but who have left their beneficent influence indelibly stamped upon the pages of our history.

At the time of which I speak, organized medicine was really casting aside its swaddling clothes, and was becoming a recognized force in the State, but it was not until the year 1902 when the American Medical Association offered its plan of reorganization, and the following year when the plan was adopted, that the Florida Medical Association took its place in the front ranks of organized medicine.

A new stimulus was thus injected into the life of the organization, and a gradual, but continuous growth was apparent from that time.

In later years, however, this growth has not kept pace with that of many other State associations, which fact should impel us to seek for causes responsible for

retarded growth. To speedily overcome this apparent inertia there are not a few members who believe that the time is propitious for an actual revolution in the conduct of our organization along certain well defined lines of activity.

It is a well established fact that scientific progress and endeavor have far outstripped medical economics, and we find our medical laws woefully antiquated and inefficient in application as compared with similar laws of most of the other States. It is a well known fact that State after State is adopting a central or single board with representation from other schools of medicine who already have separate boards of their own, and it is to the credit of this Association that an effort was made at the last session of the legislature to pass a bill creating such a board for this State.

Since 1907 the Florida Medical Association, through its Committee on Legislation and Public Policy, has attempted to pass a bill through the legislature, at its various sessions, creating a modern and efficient medical examining board, but for various reasons (chief among which is imperfect organization) success has not crowned our efforts.

We can not conceal the fact, even if we so desired, that all of the so-called irregular schools, including the Christian Science sect, have had their representatives at Tallahassee each legislative session, and their separate or combined activities have succeeded in defeating every bill this Association has ever had introduced. As these are cold facts which can not be successfully controverted, does it not seem to be the part of wisdom, as well as direct duty, that

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

the county societies holding charters from this Association be made to comply with Section 5, Chapter 12 of the By-Laws, and accept for membership "every reputable white and legally registered physician who is practicing or who will agree to practice, non-sectarian medicine?"

I firmly believe that if a proper effort was made by the county societies to enroll all of the eligible material within their jurisdiction that the membership of this Association could easily be swelled to a thousand members.

I know of no more effectual plan to disarm an enemy than by sincere friendship, and the adoption of a common cause for mutual benefit. Then why not abandon the idea of exclusiveness, and not only invite members of other schools who are eligible to membership, but, to use a common phrase, "go after" them and *impel* them to unite with the county society,

With a united profession, we could go to Tallahassee and *demand* what we have heretofore humbly sought; and, too, with an enlarged treasury, a thoroughly competent agent could be kept at Tallahassee during the whole of each legislative session, who would further and protect our interests.

In this manner we could not only secure the passage of a bill providing for a modern examining board, but could force the now legalized ignorant midwife to cease from the slaughter of confiding mothers and innocent babes. We could have expunged from the statute books the iniquitous license tax on physicians and keep it expunged.

Let the members of the county societies enter local politics by seeking election as members of the county executive boards, and in this way become intimately acquainted with the State senators and representatives. Let the county societies promote the candidacy of friends of the profession, and vigorously punish our known enemies, as well as reward our friends. By way of parenthesis I will state that the members of the county societies in West Florida are

endeavoring to defeat a candidate for congress, who as State senator a year ago was largely responsible for the defeat of the medical examining board bill.

All reform measures have exacted personal sacrifices on the part of the devotees of a cause, so why should not a doctor be willing to wield his influence, devote his time, and spend his money for the advancement and elevation of his profession?

With a thousand members on its rolls, the Florida Medical Association should easily control the votes of five to eight thousand electors, and thus demonstrate to the politicians its ability to carry a close election.

The reasonable deduction to draw from the foregoing statement is, that lack of organization and fixity of purpose were the factors which were responsible for our many defeats at Tallahassee in the past twenty years.

The logical question then arises: How are we to profit by past mistakes, and to win success in the future?

A practical method of stimulating interest in this great work would be to employ the services of a good field secretary to canvass the whole State, county by county, and organize county societies where none now exist, and persuade every society to lay aside personal prejudices, and take into the society every eligible within the county. Both the American Medical and the Southern Medical Associations have placed strong men in the field, and the wonderful success of the plan has amply proven its wisdom. It is more than probable that the services of a good man for the work could be secured at a cost of, say, ten or fifteen dollars per day and traveling expenses; and a period of six or seven weeks should be ample time in which to cover the State. In my opinion, the new members thus secured would, in two years or less, more than pay the cost of the canvass. The stimulus thus injected into the body medical would arouse such a wave of zeal and enthusiasm,

that its good effects would be felt for years to come. It therefore only remains for us to determine whether we will "go after" what we so much need and desire, or continue the old drifting policy which has so many times wrecked our efforts for modern medical legislation.

In the language of a great statesman, "we have reached the parting of the ways," and if we do not grasp such an opportunity to shape the policies of this Association in conformity with the spirit of the times, it is far better to dispense with the services of our Public and Legislation Committee, and reconcile ourselves to the continuance of a system which is a disgrace to the citizenship of the State.

THE KARELL-KUR.*

THOMAS TRUELSEN, M. D.

Tampa, Fla.

Almost fifty years ago Th. Karell, a physician in ordinary to the Russian court, reported in a lengthy article his favorable experience with milk diet in a large number of varied cases. In this article¹ he stated that during thirty-four years of active practice his faith in a good many drugs had been shaken considerably. Diet, he said, has much to do with the good results in medicine. In some of his travels as attendant to Emperor Nicholas of Russia he noted the beneficial effects of milk diet in various epidemics. His interest in the matter incited him to study all the available works at the Imperial Library on the subject of milk as a diet in various diseases. Beginning with Hippocrates and ending up with contemporaries, he reviewed all the literature upon the subject.

The "Milchkur," or course, was carried out by him in the following manner: In

the beginning all food but milk was excluded. This was given to patients at four-hour intervals, 3-4 times a day in the amount of 3-6 ounces. The patients were ordered to sip it slowly, a swallow at a time, so as to facilitate a sufficient amount of saliva reaching the stomach. He advised his patients to secure good country milk of neutral reaction (milk from city cows almost always gives an acid reaction). He allowed the milk to be taken at room temperature or lukewarm. The quantity was gradually increased. He often noticed that patients who took 10-12 small glasses a day did not do so well as when they took only 4 glasses. He also used other measures and added other articles of food in experimental cases, but in none of these did he obtain as brilliant results as when he adhered strictly to his plain milk regime. Patients requiring laxatives were ordered rhubarb, or castor oil, or water enemata. If constipation became stubborn he added boiled prunes, or a baked apple to the diet. Borborygmus and diarrhoea meant to him that the milk was too fat, or that the quantity was too large. Water was allowed those who complained of thirst, and a roll with salt, or a Holland herring, those who craved consistent food.

He cited many case histories that showed splendid success in cases of dropsy, severe anemia, hysterical and hypochondriacal conditions. He also treated with success stubborn dyspepsias, rheumatic and gouty conditions. Much success was obtained in cardiac cases, especially those suffering from decompensation and renal complications. This group often responded to the "Milchkur" when all other measures had failed. All told, he wrote, his results were far more brilliant with his "Milchkur" than with any other method he employed. However, he stated expressly that he did not want it understood that milk would cure everything.

This splendid article of Karell's did not receive the notices it merited, and its recommendations at no time became familiar to the general profession. The treatment

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

¹Ueber die Milchkur, St. Petersburg Med. Wochenschr. 1865.

seems to have been resurrected, for more recently we have been getting reports on this so-called Karell-Kur, or course, especially from German workers. American reports on groups of cases have not come to my notice.

The simplicity of this dietetic regime, and its efficacy as a therapeutic measure in troublesome cases of fairly common occurrence make it seem apropos to present this subject for your consideration.

In its practical application the Karell-Kur is administered about as follows: The patient receives daily 200 cc. of raw or cooked milk every four hours until 800 cc. have been taken. The temperature of the milk is immaterial and may vary. During the first 5-8 days nothing more is permitted, neither fluids nor solids. During the next 2-6 days conservative additions of egg, zwieback, bread, fruits, vegetables, meats, etc., are made, so that at the end of about the twelfth day the patient is back again on a fairly liberal mixed diet. This is continued for from 2-4 weeks according to the exigency of the case, without, however, increasing at any time the fluid intake above 800 cc., a part of which may be tea during the latter part of the course. The patient begins the course in bed. One or two general massages are usually helpful. Graduated resistance exercises are sometimes added. A free bowel movement must be secured daily.

This, in outline, is the so-called Karell-Kur as it is administered in the Eppendorfer krankenhaus of Hamburg, where it was popularized by the late Professor Lenhartz. *The special feature* of the Karell-Kur is the restriction to a small quantity of milk exclusively during a varying period of from 5-6 days to a week or more. With the sparing addition of solids after this period the fluid intake must not be increased for several weeks.

This strict regime is a decided starvation course, the 800 cc. of milk representing approximately 520 calories, or only about one-

fourth the number required by persons in the ordinary walks of life. Under-nourishment and weakness from this starvation period are only theoretical fears, and are ungrounded, for all authors who have applied the course have been surprised repeatedly to establish how well the patients stood it, and especially how little they complained of hunger and thirst.

The chief object of the Karell-Kur is to unload the system and to disencumber the heart as rapidly as possible. This it does surprisingly well. The rest in bed lends support to nature's recuperative forces, the small quantity of food allowed at sufficiently long intervals does not tax the digestive apparatus, but is merely sufficient fuel to keep the whole machinery going. Diuresis sets in early and increases, usually reaching its height about the third or fourth day, then it gradually declines, still the quantity of urine passed remains higher than the fluid intake for several days. Usually the quantity passed is 2-3 times the fluid intake, and occasionally the surprising quantity of 4-5 litres is recorded with a decrease in weight of from 15-30 pounds in the first week or ten days. Coincident with the objective improvement is the betterment of the patient's subjective well-being. The distressing dyspnea or orthopnea are relieved, anxiety and a feeling of oppression are changed to hopefulness, and nausea and aversion to food disappear. Usually, in several days the whole aspect of the case is so improved that the patients are again able to breathe with ease and sleep with comfort in any chosen position. This subjective improvement more than anything else makes these patients grateful, and often enthusiastic, in the continuance of the discipline that, in the beginning, may have invited their opposition because of its seeming severity.

Several factors must be considered in explaining the successes of the Karell-Kur. First, the reduced intake is of some importance. It makes practically no demand up-

on the embarrassed circulatory system and permits it the better to cope with its burden. Surprising reduction in weight of 2-4, even 8-10 kg. (4-20 lbs.) during the first several days is noted. This reduction is primarily due to elimination of water, the cause of which must not be sought exclusively, however, in the small intake, because a gratifying reduction can often be achieved also when we allow a considerable amount (1-2 litres) of water or tea in addition to the prescribed quantity of milk (Cases cited by Hegler, *Münch. Med. Wochenschr.*, 1911, No. 4; Reiss and Meyer, *Deutsche Med. Wochenschr.*, 1910, No. 6).

Another and more important consideration is the fact that milk diet is practically a sodium-chloride-free diet, and a measure of rapid dechlorization. A diet of 800 cc. of milk contains approximately only one gram. of sodium chloride. In the course of a Karell-Kur, especially in decompensation, patients eliminate regularly very considerable amounts of sodium chloride, during the first three days 8-10-15 grms. From the 5th to 8th day the elimination is not so great, 1-2 grms. being the average amount. Later, with additions to the milk diet, the elimination of sodium chloride will occasionally be below the intake for several days. If, however, the observations are extended over 3-4 weeks it will be found usually that 40-60 grms. of sodium chloride will have been eliminated in excess of the intake. These figures will mean more to us when we remember that normally we eliminate 10-15 grms. of sodium chloride daily. This is derived from our food. If the amount of nourishment is diminished, a decrease in the elimination of chloride is observed. If we carry our dietary restrictions to the point of starvation, the chlorides disappear almost entirely from the urine. But during Karell-Kur, which is practically a starvation period, our patients eliminate chlorides in large quantity, showing that they must have had a retention, the release of which, together with the concomitant elimination

of large quantities of water, is a responsible factor in the patient's improvement. Not all the symptoms of a severe decompensation, however, are due to the retention of sodium chloride and water. Such symptoms as headache, nausea, stupor, etc., are considered as being due to retained toxins, the elimination of which probably proceeds hand in hand with the increased diuresis. The improvement in these toxic symptoms at least seems to lend support to this supposition.

A third factor in the weight reduction and improvement during a Karell-Kur is the insufficient proteid content and small number of heat units in the dietary allowance. The proteid content is not sufficient to maintain nitrogen equilibrium, and the heat units furnished are far below the normal requirements. The deficiencies must be made up, and the economy is constrained of necessity to draw on its surplus of fat, eventually also on its proteid, to do so.

CASES SUITED FOR THE KARELL-KUR.

In studying the groups of cases most favorably influenced by the Karell-Kur we must conclude that they are the cases in which cardiac insufficiency predominates the picture as we find it, *e. g.*, in the cardiac disturbances of the obese, and in chronic emphysema and bronchitis when increasing weakness of the right heart manifests itself. Cardiac asthma when due to myocardial changes is often surprisingly benefited; so also is angina pectoris, especially the mild form in which the attacks are not severe but frequent. Particularly good results are obtained in these patients when they are inclined to plethora and meteorism, in whom the attacks occur when the stomach is full or the intestines distended. Valvular defects as such are no indication for the Karell-Kur; but when the myocardium becomes insufficient, and edema and dyspnea, and other signs of a decompensation become manifest, brilliant results will often be obtained. Nephritic insufficiency does not

lend itself very well to the "Kur," nor do cardio-nephritic troubles. Uremic symptoms are said to be a contra-indication.

In applying the Karell-Kur it may be used alone and often achieve much good, or it may be used in conjunction with other remedial measures. In other cases it may alternate with drug courses. As in the application of any other remedial measure, the intensity, the length, and the repetition of the "Kur" must be strictly individualized in order to secure the best results.

The absolute failure of the "Kur" used either alone or in combination with other remedies indicates a grave prognosis.

SUMMARY.

The Karell-Kur is a helpful measure in the treatment of various troublesome cases, but especially in cases that are dependent upon cardiac insufficiency for their symptomatology. Its rigidity, its duration, and its repetition, must be left to the discretion of the supervising physician. In the Karell-Kur, as in all other remedial measures, individualization is essential to success. The Karell-Kur may be depended upon alone, or drugs may be added, or sometimes drug courses may advantageously alternate with it. In explaining its beneficial action we must bear in mind, first, that the greatly reduced intake makes practically no demands upon the embarrassed circulatory system and permits it the better to cope with its burden; second, that it is practically a sodium-chloride-free diet and a measure of rapid dechlorization and dehydration; third, that the elimination of toxins is probably also a factor in the improvement of the patient.

A grave prognosis is indicated by the failure of a Karell-Kur that has been applied with circumspection.

EMETINE IN DYSENTERY.—Emetine is a specific in the treatment of amebic dysentery.

It is quickly absorbed and its effect is rapid and striking. It produces no unfavorable symptoms such as nausea, vomiting, and depression.—Julius Friedenwald, M. D., and Lewis J. Rosenthal, M. D., in *New York Medical Journal*.

DIAGNOSIS AND TREATMENT OF VENEREAL ULCER.*

WALTER P. DEY, M. D.,
Jacksonville, Fla.

When we speak of venereal ulcer, in the general acceptance of the term, we mean to imply a chancroidal or nonsyphilitic ulceration due to a specific microorganism, namely, the strepto-bacillus of Ducrey.

It seems to be rather a common practice amongst medical men, when a genital ulcer is presented for diagnosis to consider it either as chancre or chancroid, so much so that little or no thought is given other causative agents, any one of which may produce an ulcer that from its clinical aspect is identical with either a so-called hard or soft chancre.

Your text books as a rule name the following conditions in differentiating them from chancroid or true *ulcus molle*:

Hard chancre or the primary lesion of syphilis,
Herpes genitalis,
Scabies,
Gumma,
Epithelioma.

The cardinal differential symptoms and signs you are familiar with, but while more or less stress is laid upon the period of incubation, the characteristic undermined edges, absence of induration, pain, and tenderness, character of the discharge and adenopathy, all authorities conclude by advising extreme caution before giving an opinion, depending more or less for a final conclusion on the bacteriological examination.

The number and variety of types of non-syphilitic genital ulcers so frequently cited in the current medical literature which are not true chancroids but due to the loss of tissue substance from such conditions as hospital gangrene, trophic disturbances,

*Read before the forty-first annual meeting of the Florida Medical Association, at Orlando, May 13-15, 1914.

some forms of balanitis, and secondary infections, and lastly a spontaneous idiopathic affection, all of which clinically correspond to the phagaedenic type of chancroid, clearly demonstrate the difficulty of deciding the causative factor merely by inspection.

Histologically we know that *ulcus venereum* shows a round cell infiltration with the production of a sero-purulent secretion, on the other hand the last group mentioned show an inflammatory process accompanied by the production of a fibrinous exudate with the occurrence of an early coagulative necrosis. For example, at the present time no specific organism can be identified with the causation of *ulcus gangrenosum*, but polymorphous gangrenous ulcers have been described in which the etiological factors were found to have been the tubercle bacillus, the bacillus of diphtheria and the bacillus of Plaut-Vincent angina, in other cases lesions which gave every appearance of phagaedenic chancroidal ulcers later proved to be the primary sore of syphilis, even after diligent search had been made for the spirochetæ and the bacillus of Ducrey without success.

Extra genital chancroids while of rare occurrence present the same difficulties of diagnosis, unless associated as they usually are with genital lesions and the result of autoinoculation—a chancroid of the finger, for example, will simulate a paronychia, a circumscribed phlegmon or an ulcerated pernio.

From the standpoint of clinical diagnosis Seibert calls attention to the fact that a chancroidal ulcer itself is painful while there is an absence of pain in the surrounding tissue, the remarkable resistance to the ordinary methods of treatment, the tendency to rapid ulceration and the progression of the destructive process under apparently healthy normal skin. It is the contention of the writer, however, that the diagnosis of any genital ulcer is almost wholly dependent upon the bacteriological findings, and when, as at the present time, every doctor practic-

ing in this State has at his command the services of expert bacteriologists at any one of the three State Health Board Laboratories, there is scarcely an excuse for the man who fails to submit slides as a routine measure in order to better diagnose these conditions. We are all agreed, for instance, that the administration of salvarsan in the primary stage of syphilis shortens very materially the otherwise long antisyphilitic treatment and this is only possible when we learn to look with suspicion upon every genital lesion and obtain smears for examination especially in that type which clinically presents the appearance of the typical chancroid, for we can never tell when we have to deal with a double infection or the so-called mixed sore.

The method for obtaining smears from a genital ulcer, as usually employed, is as follows: The lesion from which the smear is to be obtained is cleaned with water or soap and water if necessary, to remove crusts, detritus, etc., from the surface of the ulceration—with a platinum loop, or small curette, a smear is made from the surface well under the edge; the lesion should then be scraped at a point where the sound and ulcerated tissue approximate, that is, at the margin of the ulceration. Bleeding will result, which should be wiped away, as only serum is desired, and the curetted area squeezed firmly until bleeding is checked, and on removal of the compress a flow of serum will take place, one or two drops of which are placed on each of several slides, spread out thin and allowed to dry in the air, after which they are ready to be stained and examined.

The first or surface smear which should show strepto-bacilli, if present, stain readily with any of the ordinary bacterial stains and the organisms appear as short, thick oval bacilli with rounded ends and two lateral indentations which sometimes give them the appearance of the figure "8." The ends are more deeply stained than the central portions and they have a tendency to

form chains and are frequently seen in the epithelial but rarely in the pus cells. In staining the serum-smears for the spirochetæ somewhat more technique is required if the ordinary methods of Romanowski, Leishmann and others are employed. The simplest method, however, for the man who does his own microscopical work is the India ink method—one drop of serum with one drop of India ink, mixing the two and drawing the mixture over the slide with the edge of another clean slide as in making a blood smear, and allowing to dry. The field is observed with the oil immersion lens as a brown color, with the blood cells and the spirochetæ shining through as colorless refractile bodies.

The treatment, from a prophylactic standpoint, is cleanliness. The curative procedures for the treatment of chancroid are about as varied and numerous as for other venereal affections. The local treatment that has given the best results in my hands and the one I employ almost exclusively is as follows: The parts are cleaned thoroughly with green soap and warm water; the surface of the ulcer is anesthetized by applying a pledget of cotton saturated with a ten per cent solution of cocaine or alypin, occasionally, if the lesion is small, cocaine crystals are applied. After five or ten minutes the surface and particularly the edges are curetted, after which, if active ulceration is present, fuming nitric acid or pure phenol is applied by means of a small cotton applicator. Should the lesion be more indolent in character, only phenol is applied, followed immediately by 95 per cent ethyl alcohol.

A wet dressing composed of tincture of iodine 30 drops, distilled water 8 ounces, is employed. Of material assistance in maintaining moisture is the use of gutta percha tissue, or an ordinary rubber condom over the dressing, especially is this to be desired during the night. This dressing is continued until the lesion assumes a healthy granulating appearance, any new areas of

infection being cauterized daily should they appear.

With the advent of a healthy surface any of the bland antiseptic dressing powders may be used, by preference a mixture composed of equal parts of bismuth subnitrate, calomel and oxide of zinc, or ten per cent balsam peru in castor oil.

In the treatment of the phagadanic type, as well as the sore that has a tendency to resist treatment and become indolent, especially where the inguinal glands have become involved and assumed a chronic suppurative condition with marked infiltration of the surrounding tissues, the administration of the mixed vaccine has given most gratifying results, so much so that recently the mixed vaccines are administered as soon as the diagnosis is made and the local treatment instituted in the belief that this disagreeable complication may be prevented.

In conclusion I wish to offer the following summary:

The diagnosis of chancroid is only possible by means of laboratory methods;

It is the duty of the physician to resort to laboratory methods for diagnosis in every case of genital ulcer that may present itself for treatment;

The intense manifestations of buboes and chancroids are caused perhaps not only by the direct action of the strepto-bacilli but by simultaneous anaphylactic reaction on the part of the organism;

The vaccine treatment of buboes with strepto-bacillus or mixed vaccine gives quick and excellent results.

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SAND-SPUR IN THE LARYNX—ITS REMOVAL, WITH REPORTS OF TWO CASES.*

CALVIN D. CHRIST, M. D.,

Orlando, Fla.

Foreign bodies in the larynx are of comparatively frequent occurrence. Almost every conceivable kind of an object has been reported from time to time as having been removed from the larynx, and considering the position of the larynx, its extreme accessibility, is it not a wonder that a great many more foreign bodies do not enter it?

A sudden inspiratory act while eating, or while holding something in the mouth, is usually the way foreign bodies enter the larynx. Both fluids and solids find their way into the open air passages during the acts of mastication and deglutition. Objects held in the mouth are frequently drawn into the larynx, a sudden fright, laugh or injury causing one holding an object in the mouth to make a sudden inspiratory effort, causing the foreign body thus held to be drawn into the larynx.

Sudden death has not infrequently been caused by laryngeal obstruction due to foreign bodies. Smooth or round bodies are not, as a rule, difficult of removal; in fact, the unfortunate usually coughs them up. Irregular bodies, burrs, fish bones, pins, needles, etc., are not, however, so easily gotten rid of, and are frequently only removed after very tedious and difficult efforts, and in some cases only after operative procedure, which was the method re-

sorted to in the removal of the sand-spur cases I now wish to report.

CASE 1.—F. R., a little girl, age ten years, came to my office, coming eleven miles from her country home, saying she had a sand-spur in her throat. She gave the following history: Having recently come from Kansas and encountering several sand-spurs since in Florida she had gotten her fingers pricked several times, so was afraid to pick them off her clothes any more with her fingers. Seeing a sand-spur on the sleeve of her dress and remembering her past experiences of picking off a spur with her fingers she put her arm up to her mouth and caught the spur between her teeth. Her tongue came in contact with the spur, the pricking and painful sensation of the spur to the tongue caused her to make a quick, deep inspiration, drawing the spur directly into the larynx below the vocal cords. This happened three days before I saw the child. The throat was very much inflamed but breathing was not seriously affected. She was practically free of pain.

Laryngoscopic examination easily revealed the spur in the larynx, a little to the left and behind the true vocal cords. I cocaineized the pharynx and larynx thoroughly and made repeated efforts to extract with laryngeal forceps. My progress was very good until I reached the true vocal cords, which contracted every time my forceps came in contact with them. I then bent a pair of forceps to reach the larynx and thus was able to hold the cords apart but this carried the spur out of sight behind the cords, making it impossible to grasp the object with another pair of forceps.

I advised tracheotomy as the safest procedure, but the parents objected to an operation. As the spur had been in there three days and there was already inflammation around the cords, I told them I would wait until the next morning, when under general anesthesia I would again try to remove the spur, but if I failed would advise a tracheotomy. I found it a more difficult

*Read before the Forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

task to enter the larynx and pick up a foreign body under general anesthesia than I thought it would be.

I then proceeded to do a high tracheotomy, getting in above the isthmus of the thyroid. It was only necessary to open the width of one cartilage, through which, with a small curved hemostat in the trachea and a finger through the mouth into the larynx, I was easily able to pick up the spur and remove it.

I closed the laryngeal cartilage first with number one plain cat-gut, the fascia and the muscles with plain cat-gut and the skin with silkworm-gut, putting in a small drain down to the cartilage. There was a slight infection of this wound coming from the secretions of the trachea; drainage was complete in about three days.

The child left in ten days, completely cured. Her voice at last reports was practically normal, although extensive inflammation of the vocal cords had taken place.

CASE 2—M. R. B., a little girl, age ten years, living four miles in the country, came to my office with a sand-spur in her throat and gave the following history: While eating a piece of buttered bread the child suddenly stopped eating and going to her mother told her that she had swallowed a sand-spur that happened to be on her bread. Upon a laryngoscopic examination I was able to see the spur behind the vocal cords, situated entirely in the larynx.

As soon as the child found out that she really had a spur in her throat she became panicky and it was impossible to do any more with her, so as it was not obstructing her breathing, I left her alone until the next morning, when under general anesthesia I made an effort to remove the spur without operation, but failed to do so.

I then did a high tracheotomy, removing the spur with ease. In this case making the trachea opening was a little more difficult owing to the short neck of the child and the isthmus of the thyroid being so high up on the trachea. I did not divide

the isthmus of the thyroid but detracted it slightly from its upper border and retracted it when I was able to enter the larynx without any serious bleeding.

I closed the deep wound with plain cat-gut and the skin with silkworm gut as in the previous case. This wound practically closed by primary union.

I have not been able to find any published reports concerning sand-spurs in the larynx and am sure similar cases must have occurred a number of times before but that they have not been reported.

PROPAGANDA FOR REFORM.

SCOPOLAMIN - MORPHIN ANESTHESIA.—*McClure's Magazine* for June contains a sensational account of the use of scopolamin-morphin in anesthesia as used by Krönig and Gauss at Freidburg. In America the scopolamin-morphin anesthesia has received little attention. It is far from safe and can be carried out only in hospitals. Morphin and scopolamin should not be used in fixed proportions. (*Jour. A. M. A.*, June 6, 1914, pp. 1815 and 1829.)

GLYCO-HEROIN, SMITH.—A report of the Council on Pharmacy and Chemistry explains that Glyco-Heroin, Smith, although containing $\frac{1}{16}$ grain heroin to the teaspoonful, is exploited in a way to encourage self-drugging by the layman. The advertising matter suggests the administration of Glyco-Heroin, Smith, to children and much of it has contained the evident falsehood that this heroin mixture does not produce narcotism or habituation. The possibility of habit formation should be sufficient to induce the thoughtful physician to avoid the use of Glyco-Heroin, Smith. (*Jour. A. M. A.*, June 6, 1914, p. 1826.)

BUCKHORN LITHIA WATER.—This water was declared misbranded by the federal authorities because false curative claims were made for it and because it did not contain enough lithia to be entitled to its name. (*Jour. A. M. A.*, June 20, 1914, p. 1981.)

PROCEEDINGS OF THE FORTY-FIRST ANNUAL MEETING OF THE FLORIDA MEDICAL ASSOCIATION.

The forty-first annual session of the Florida Medical Association convened at the Elks' Club in the city of Orlando, Fla., May 13th, 1914.

The Association was called to order at 2:30 p. m. by Doctor G. E. Edwards of Orlando, Chairman of the Entertainment Committee.

The Rev. J. W. Stagg, of the First Presbyterian Church, opened the meeting with prayer.

Addresses of welcome were then delivered by Hon. Joseph H. Jones, President of the Orlando Common Council, in behalf of the city of Orlando; Hon. John M. Scheney, in behalf of the Orlando Board of Trade, and Doctor Calvin D. Christ, in behalf of the Orange County Medical Society.

Dr. J. G. DuPuis, of Lemon City, First Vice-President of the Association, in a few well-chosen words responded to these addresses and thanked the various speakers for the cordial welcome extended the Florida Medical Association.

The meeting was then turned over to the Scientific Committee, Dr. Gerry R. Holden, of Jacksonville, presiding.

The following papers were read and discussed:

"Organized Medicine and Legislation," by Dr. J. H. Pierpont, of Pensacola.

"The Family Physician and the Public Health," by Dr. C. E. Terry, of Jacksonville.

"Medical Inspection and Education of School Children the Most Probable Solution of Hookworm, Malaria and Other Infectious Diseases," by Dr. J. C. Davis, of Quincy, Fla.

"The Diagnosis of Pulmonary Tuberculosis," by Dr. R. H. McGinnis, of Jacksonville.

As a mark of respect to the late Secretary of the Association, Dr. J. D. Fernandez,

the Association then adjourned until 8 p. m.

The House of Delegates was called to order at 8:00 p. m., by Dr. J. G. DuPuis, First Vice-President, who presided in the absence of Dr. Paul C. Perry, the President, who was prevented from attending the meeting by illness.

It was moved by Dr. E. W. Warren, of Palatka, and seconded that the paper of Dr. J. H. Pierpont, entitled "Organized Medicine and Legislation," be referred to a special committee of three, and that they be instructed to confer with the Standing Committee on Legislation and Public Policy with the view of making a report concerning the suggestions offered in this paper. Carried. The Chair appointed Dr. E. W. Warren, Dr. N. A. Baltzell and Dr. G. B. Glover.

The President's address was then read by the Secretary.

PRESIDENT'S ADDRESS.

To the Florida Medical Association:

GENTLEMEN — During the year that I have served as your presiding officer I have considered the needs of the Association and reviewed its past history and progress, which is apparent to most of you, namely, that for the past ten years this Association has remained at a standstill, and but for the combined efforts of a few of the older members of the profession I am sure the same would have passed out of existence.

The time is now ripe for doing that which is mostly needed, namely, to abolish the publication of our annual report and use the moneys thus saved for completing a thorough medical organization in each and every county in the State of Florida. In a "rough" way I would suggest that committees or a committee be appointed to formulate a plan which can be enacted and put into effect immediately after this annual meeting. I have looked into the matter with some care and I am sure that this can be done without violating any part of our Constitution or By-Laws. The suggestions I have to offer are as follows:

First—That we discontinue the publication known as "The Annual Report of the Florida Medical Association," which costs in round figures about \$550 each year for printing, stenographer, mailing lists, etc.

Second—That a suitable resolution be drawn and passed at this meeting authorizing the expenditure of such moneys as the treasurer may have for medical organization.

Third—That another set of resolutions be passed by the State body authorizing the committee or the president and secretary (at the will of the body) to borrow such money as is needed from a banking institution to cover up the deficit. (I have arranged this matter so that the Barnett National Bank of Jacksonville will be glad to loan to the Association such amounts as it may be found necessary to expend in this direction.)

Fourth—That the Association also pass a resolution authorizing this committee or the officers of the body to hire a doctor at a salary not in excess of \$150 a month and traveling expenses to go from county to county where medical organization is not present and there form a medical society, permitting the officers of the body to furnish them a charter and full membership to the State organization, and that the secretaries of such societies be instructed to send the annual dues for the year of 1914 to the secretary and treasurer of the State organization.

In talking this matter over with our State Health Officer, Dr. J. Y. Porter, he thinks that it is possible for one man to cover the entire State in four months; that the actual expense of railroad fare and hotel bill for such a representative would not be in excess of \$125 a month. Figuring along this line we would spend, if this is put into effect, somewhere in the neighborhood of \$900 to \$1,100. The amount that should be in the treasury at the close of this annual meeting and which we have heretofore spent on a useless proposition should amount to about \$700. Therefore, the borrowing of from

\$600 to \$700 more and acquiring thereby some 400 to 600 members would mean a net profit to the Association in the four months of from \$600 to \$800.

I have talked with many members of the profession throughout the State during the past year along this line and each and every man has expressed himself as being in hearty accord with the proposed plan; but the details of this must be worked out by the Association and such resolutions passed as will make it possible for no hardship to occur to any member of the profession in becoming a member of the Association. As an illustration of this I would cite the following example that might arise:

Dr. A., living near the boundary line of, we will say, Duval county, and the nearest and most convenient meeting point to him would be, we will say, St. Augustine, it would certainly be right and proper that he be permitted to join the society at St. Augustine rather than that of Jacksonville. It must be made clear to the minds of every one present that this effort is intended to get into this Association as many members as is possible, and that one county must not have jealousy as against another and consent to this "free-lance" method of obtaining membership.

Again, if we accomplish the desired results and at the end of two years have a membership that will number one thousand in place of approximately four hundred, as now; when the legislature of Florida meets in its next regular session we should have sufficient funds in the treasury to keep a committee of reputable men at the capital and prevent nefarious and outrageous legislation, and at the same time secure for the doctors of the State of Florida that which they have most desired, namely, the passage of a medical practice act that will hold and be constitutional.

It must be a fact that to secure proper legislation certain men must be kept there with sufficient means to entertain and interest one in the house and one in the senate

to see that these bills are properly presented and at the same time to meet and thoroughly discuss with the other members of the medical profession, such as the homeopath and the allied cults, as Christian Scientists, chiropractics, eclectic and other forms of crooks, who are always present and are ready to spend their money in defeating any measure that has been put before the house that carries with it weight and policy.

The progress as made in this past year is very slight along medical organization lines, but it is my pleasure to state that from four to six new societies have been formed with a fairly good membership, and that some of the societies that were dead and inactive have been brought back to life.

It is proper that at this time I should call to your attention a bit of disturbance that arose in Volusia county as the result of a certain resolution that was passed at our last meeting at Miami. Members of the profession from Volusia county reported that the society had been inactive and that no meetings had been held for three years. The State Society at the time passed a resolution authorizing a letter to the secretary of Volusia County Medical Society at Daytona asking him to at once call a meeting and hold an election of officers and thereafter to hold stated meetings throughout the year.

Our late Dr. Fernandez complied with those resolutions, writing Dr. Klock, who was then secretary of that society, and up to the time of his death Dr. Fernandez had not received reply from Dr. Klock. Knowing this to be true, and as your presiding officer, I instructed Dr. Foster of that county to issue a call for such a meeting, which was done, and new officers were elected, and Dr. Klock was asked to turn over such papers as he had in his possession. This, I am told, Dr. Klock declined to do.

I then wrote Dr. Klock and told him of the resolution as passed in Miami and of the authority that I had given Dr. Foster, and stated to him in that letter that if he had any grievance whatever that the State

organization would be pleased to hear it at the meeting in Orlando, and until such time that he refrain from calling another meeting and electing officers, which he attempted to do in the latter part of February. Dr. Klock was not kind enough to answer this letter and it is possible that this matter will have to be attended to in the meeting of the Council.

I would further suggest that a committee be appointed to pass suitable resolutions upon the death of our late secretary, Dr. J. D. Fernandez.

It is with the deepest regret that I am forced to be absent from this meeting as a result of ill-health. At present I am in Rochester, Minnesota, under the care of Dr. Mayo, but hope to return to our fair State in a short time in perfect health. I assure you that at our next regular annual meeting (which I hope will be held in Jacksonville) I shall be present and continue my efforts for the furtherance and progress of this State organization.

If there is any reason for assigning work to me during my absence I shall be pleased to comply with it at as early a date as is possible.

Wishing for this meeting a wonderful success and a lot of profitable work, I am,

Most cordially, your president,

P. C. PERRY.

Rochester, Minnesota, May 5, 1914.

It was moved and seconded that the President's address be received, placed on file and the Secretary authorized to send a telegram to Dr. Paul C. Perry expressing the regret of the Association over his illness and absence from the annual meeting, and wishing for him a speedy recovery. Carried.

The following reports of the Secretary and Treasurer were then read:

SECRETARY'S REPORT.

To the President and Members of the Florida Medical Association:

I can only report to you for the past six months. Owing to the death of Dr.

Fernandez, our President appointed me to serve as Secretary and Treasurer until the annual meeting. The illness and death of Dr. Fernandez was so sudden that he had no opportunity to turn over his property as Secretary and Treasurer to his successor. In going over his effects practically no records of the Association were found, so I started in with a copy of the proceedings of the 1913 meeting and of the Constitution and By-Laws, some report blanks and the Association seal.

Three hundred and twenty-four members have been reported so far. No reports from the following counties: Bradford, DeSoto, Escambia, St. Johns and Holmes.

Santa Rosa county has been reinstated and new societies established in Pinellas and Sumter. Leon and Gadsden have formed a joint society, which the Councilor reports to be a very advantageous arrangement. If the secretaries of all the counties would send in their reports more promptly and make them more complete the business of the Association would be very much facilitated.

JAMES D. PASCO, M. D.,

Secretary.

TREASURER'S REPORT.

To the President and Members of the Florida Medical Association:

I beg to make the following report as treasurer of the Florida Medical Association. The following amounts have been received from the secretaries of the county societies:

Alachua County	\$ 84.00
Bradford County	27.00
Brevard County	15.00
Columbia County	15.00
Dade County	60.00
DeSoto County	33.00
Duval County	291.00
Escambia County	39.00
Hillsborough County	183.00
Holmes County	6.00
Carried forward	\$753.00

Brought forward	\$153.00
Jackson County	63.00
Jefferson County	12.00
Lake County	15.00
Leon County	66.00
Manatee County	15.00
Marion County	12.00
Monroe County	21.00
Orange County	51.00
Pasco County	12.00
Pinellas County	48.00
Polk County	33.00
Santa Rosa County	33.00
Suwannee County	21.00
St. Lucie County	30.00
Sumter County	24.00
Volusia County	42.00
Walton County	15.00

\$1,332.00

Expenditures as per vouchers attached, \$185.06.

Balance on hand, \$1,146.94.

Moved and seconded that the reports of the Secretary and Treasurer be referred to a committee of three with instructions to report back to the House of Delegates. Carried. The Chair apopinted Dr. Graham E. Henson, Dr. John McDiarmid and Dr. A. C. Hamlin.

In the absence of the Librarian, the Secretary read the following report:

Florida Medical Association, Orlando, Fla.

GENTLEMEN—The Library of the Florida Medical Association consists of 254 volumes and 1,023 journals and pamphlets. The library is at present housed in the Carnegie Library of this city. The cataloguing is being carried on very satisfactorily by the employees of this library.

The library is now in such shape that it can be used by the members of the Association. Any member who desires to contribute to the same can feel that his contribution will be well taken care of.

Respectfully,

WM. S. MANNING, M. D.,

Librarian.

Upon motion duly seconded the report was received and placed on file.

The special committee appointed at the Miami meeting for the purpose of investigating and reporting the best course to pursue with the view of increasing the membership of the Florida Medical Association, reported as follows:

To the President and Members of the Florida Medical Association:

Your special committee appointed for the purpose of investigating and recommending the proper course to pursue in increasing the membership in the State Association and harmonizing the profession throughout the State looking towards the establishment of a medium of scientific, educational and social communication with the members, beg leave to report:—

That after reviewing correspondence and other data from other States to the matter in question, we would respectfully recommend that the Association attempt to issue a monthly bulletin or journal consisting of the transactions or business and the scientific matter presented at its annual meetings and such other scientific papers, news items, abstracts and advertisements consistent with the wisdom of the Publication Committee hereafter to be determined by the House of Delegates.

That the Publication Committee be composed of the Secretary and two other members as at present. The Secretary to be editor-in-chief and general manager.

That the secretaries in the local societies of the State that compose the Association be correspondents or reporters to the editor of their respective societies.

That all papers by members of the Association, scientific or otherwise, be submitted to the Editor and Publication Committee for publication.

Respectfully submitted,

A. H. FREEMAN, M. D.

R. H. MCGINNIS, M. D.

It was moved and supported that this report be received and that the discussion of same be made a special order of business upon the convening of the House of Delegates at 11 a. m., May 14th. Carried.

The Committee on Legislation and Public Policy made the following report:

To the House of Delegates, Florida Medical Association:

GENTLEMEN—Your committee has prepared and mailed a circular letter to 260 members of the profession, giving an outline of the desired legislation and urging that the profession see all candidates for representatives and senators in the coming primaries and show them the great need of medical legislation at the next session of the legislature.

Your committee has corresponded with members in different parts of the State and has had drafted a bill which we think will cover the ground and we advise that this bill as finally drafted be approved by the joint committee appointed at yesterday's session and the officers of the Association and mailed out to the members in the several counties, and that the members generally use every effort to pledge support for the measure.

Your committee further recommends that the recommendations as made in the message of our President, and also in the paper of Dr. Pierpont be adopted and that a field secretary be appointed by the President to canvass the State in the interest of the organization at a total expense to the Association not exceeding \$10.00 per day and for a time not exceeding two months.

F. C. MOOR, M. D.

J. H. PIERPONT, M. D.

C. W. BARTLETT, M. D.

It was moved and seconded that the report be received and laid over for discussion with the previous special committee's report. Carried. The expense bill of the Committee on Legislation and Public Policy for eleven dollars (\$11.00) was, on

motion, duly seconded approved and ordered paid.

The reports of the following Councilors were then read and upon motion duly seconded, accepted and placed on file:

FIRST DISTRICT.

PENSACOLA, FLA., May 7, 1914.

To the House of Delegates, Florida Medical Association:

GENTLEMEN—I beg to submit herewith a report of stewardship for the First Councilor District.

It was my pleasure to meet with the Santa Rosa County Medical Society on the night of February the 10th, and to find the society in a most satisfactory condition. The society is holding regular meetings, which are well attended, and give promise of future success.

Two appointments were made to meet with the Walton County Medical Society, but, owing to pressing duties at home at those times, I was unable to keep the appointments. Dr. McKinnon, the secretary, writes me that the society is in a live condition and doing good work. The report of this society was late in going into the State Secretary, so did not appear in the published program of the Association.

The Escambia County Medical Society has taken on new life and vigor since the beginning of the year, and now numbers nearly all of the regular doctors in the county on its roll of membership. The meetings are unusually well attended, and the fraternal spirit is being felt more and more, which fact speaks well for the county society.

This concludes a report of activities in the First District, but not of your councillor, who feeling an unusually keen interest in organization and legislation determined to canvass the whole of West Florida in an effort to arouse interest and zeal in county society work, and preach the gospel of organization.

On February 26th, last, I met with the Bay County Medical Society at Panama City, and found that the doctors in the newly created county had organized under the laws of this Association, and were doing good work. The society has applied for a charter, which will doubtless be granted at this session of the Association.

On February 27th I met with the Washington County Medical Society at Chipley, and enjoyed a warm reception from the members of that county society, and found it in a healthful condition.

An effort was made to meet with the Jackson County Medical Society, but owing to storm conditions prevailing at that time, a meeting could not be held, though I was in the county at the time and had arranged to attend the meeting, if it had occurred.

A date was arranged for a meeting of the Holmes County Medical Society, but circumstances over which I had no control kept me at home.

In the three counties where meetings were held, and which I was prevented from attending, my paper touching upon organization and legislation was read and, I have since learned, well received.

Respectfully submitted,

J. HARRIS PIERPONT, M. D.,
Councilor.

SECOND DISTRICT.

TALLAHASSEE, FLA., May 12, 1914.

To the House of Delegates, Florida Medical Association:

GENTLEMEN—Medical affairs in the Second Councilor District are in a fairly satisfactory condition.

We formed a Leon-Gadsden County Society, inviting all medical men in this District to unite with us. We now have an active membership of twenty-two members. We meet alternately at Tallahassee and Quincy, the first Monday in each month. I think our method of combining in districts where the number of physicians is limited will solve the vexed question of interesting

isolated physicians, and making them enthusiastic members of our County Societies and State Association.

Respectfully,
HENRY E. PALMER, M. D.,
Councilor Second District.

FOURTH DISTRICT.

JACKSONVILLE, FLA., May 7, 1914.

To the House of Delegates, Florida Medical Association:

GENTLEMEN—I desire to submit the following report from the Fourth Councilor District:

Members in good standing.....	96
New members elected during the past year	11
Removals and transfers	2
Dropped from membership	1
New member through transfer.....	1
Members reinstated	2
Died	1

The average attendance at nine regular and one called meeting has been 28.

It is with profound regret that I report the death of one of our oldest as well as ablest members, Dr. J. D. Fernandez.

St. Johns County: There has been no evident change as to membership or conditions, as compared with the preceding year.

Clay and Nassau Counties seem to be beyond the pale, as to the formation of a Medical Society in either county.

Faithfully yours,
EDWARD N. LIELL, M. D.,
Councilor, Fourth District.

SIXTH DISTRICT.

TAMPA, FLA., May 7, 1914.

The House of Delegates, The Florida Medical Association:

GENTLEMEN — During the last year no official business requiring my attention has come to my notice. Some two years ago I tried to aid the physicians of Pinellas County in organizing a County Society, but it failed to materialize. I have lately

learned indirectly that a Society has been organized there. Of the details I have not been informed. The Hillsboro County Medical Society has had a good year, and is in good condition.

Very truly,
U. S. BIRD, M. D.,
Councilor, Sixth District.

SEVENTH DISTRICT.

DELAND, FLA., May 7, 1914.

The Volusia County association has been inactive for three years. I did not get into correspondence with the Secretary until recently when it was decided to form a new society in which there were thirteen members. Dr. McConnel was elected president and Dr. Foster secretary; this organization to be recognized as the society of Volusia County.

J. MCDIARMID, M. D.,
Councilor.

The bill of \$1.50 for expenses of the Councilor of the Second District was on motion duly seconded approved and ordered paid.

Dr. Leon Peek stated that the present Councilor from the Eleventh District, Dr. E. E. Rollins, was no longer a resident of that district and, therefore, ineligible to serve as Councilor.

It was moved by Dr. J. H. Pierpont and seconded that Dr. W. R. Warren, of Key West, be seated in the place of Dr. Rollins. Carried.

The Chair announced that the ex-President's buttons which had been provided for by action at the Miami meeting were ready for distribution.

It was moved by Dr. G. E. Henson and seconded that a committee be appointed to escort the ex-Presidents present at the meeting to the Chair. Carried.

The Chair appointed Dr. Graham E. Henson and Dr. C. D. Christ.

The following Past-Presidents were then escorted to the Chair by this committee and presented with a button by the Chair: Dr.

J. H. Pierpont, Pensacola; Dr. H. K. Dubois, Port Orange; Dr. John McDiarmid, DeLand, and Dr. A. H. Freeman, Starke.

The Chair appointed the following committees:

Committee on Necrology—Dr. J. H. McDiarmid, Dr. H. K. Dubois and Dr. A. H. Freeman.

Committee on Resolutions—Dr. M. B. Herlong, Dr. R. H. McGinnis and Dr. E. W. Warren.

Upon motion the House adjourned until 11 a. m., the following day.

GENERAL ASSOCIATION.

The Scientific meeting reconvened at 9 a. m., May 14th, the following papers being read and discussed:

"The Prophylaxis of Typhoid Fever," by Dr. Graham E. Henson, of Jacksonville.

"Prostate Hypertrophic," by Dr. J. S. McEwan, of Orlando.

"The Diagnostic Value of Abdominal Pain in Surgical Diseases of the Upper Abdomen," by Dr. J. E. Boyd, of Jacksonville.

"Surgical versus Conservative Treatment of Joint Tuberculosis," by Dr. Ralph Duffy, of Plant City.

"A Report of a Case of Secondary Multiple Ecchinoccus Cysts of the Peritoneum Complicating Appendicitis," by Dr. John S. Helms, of Tampa.

The scientific session adjourned at 11 a. m., and the House of Delegates was called to order by Dr. J. G. DuPuis, the acting President.

Discussion on the reports of certain special committees and the Committee on Legislation and Public Policy having been made a special order of business for this hour, it was called for by the Chair. After a discussion lasting for an hour in which were advocated two policies, one the establishing of a State Journal, the other placing an organizer in the field for a period of two months, the hour for the election of officers having arrived, it was moved and seconded that both reports be laid upon the

table and further discussion on them be made a special order of business for 2 p. m., that afternoon. Carried.

The Chair announced that the next order of business was the election of officers for the ensuing year and called for nominations for the office of president. Dr. J. S. McEwan, of Orlando, placed in nomination the name of Dr. F. Clifton Moor, of Tallahassee.

Dr. G. B. Glover, of Monticello, placed in nomination the name of Dr. Calvin B. Christ, of Orlando.

Dr. J. A. Simmons, of Arcadia, placed in nomination the name of Dr. G. E. Henson, of Jacksonville. Dr. Henson requested that his name be withdrawn and that he be not considered as a nominee for the office.

It was moved and seconded that the nominations be closed and a ballot taken. The Chair appointed Dr. J. H. Pittman, of Jacksonville, and Dr. E. W. Warren, of Palatka, as tellers.

The ballot resulted as follows:

Dr. F. Clifton Moor, 43; Dr. C. D. Christ, 8; Dr. G. E. Henson, 3.

Moved by Dr. Christ and seconded that the election of Dr. Moor for President be declared unanimous. Carried.

Nominations being in order for First Vice-President, Dr. C. D. Christ, of Orlando, and Dr. J. M. Davis, Jr., of Quincy, were placed in nomination. Upon the ballot being spread Dr. Christ received 45 votes and Dr. Davis 11. It was moved by Dr. Davis and seconded that Dr. C. S. Christ's election as First Vice-President be declared unanimous. Carried.

Nominations being in order for Second Vice-President, Dr. Thomas Truelsen, of Tampa, was placed in nomination and there being no further nominations, it was moved and seconded that the Secretary cast the ballot of the Association for Dr. Truelsen. Carried.

The Secretary cast the ballot.

Nominations being in order for Third Vice-President, Dr. J. A. Simmons, of

Arcadia, was placed in nomination. There being no further nominations, it was moved and seconded that the Secretary cast the ballot of the Association for Dr. Simmons. Carried.

The Secretary cast the ballot.

Nominations being in order for Secretary and Treasurer Dr. James D. Pasco and Dr. Graham E. Henson, of Jacksonville, were placed in nomination. Dr. L. W. Cunningham was requested to act as Secretary. Upon ballot being spread Dr. Pasco received 24 votes and Dr. Henson 31.

Dr. Graham E. Henson was declared elected Secretary and Treasurer.

It was moved by Dr. Pierpont and seconded that the election of Dr. Graham E. Henson as Secretary and Treasurer be for a term of four years, beginning from the date of his election. Carried.

Nominations for Librarian were then called for. Dr. J. D. Pasco of Jacksonville was nominated and upon motion duly seconded and approved the Secretary was instructed to cast the ballot of the association for the nominee.

The Secretary cast the ballot.

It was moved and seconded that a rising vote of thanks be extended to the retiring officers of the Association. Carried.

The Secretary read the resignation of Dr. Roy E. Chandler as Councillor from the Third District, which, upon motion, was accepted.

The President then stated that the selection of a meeting place for the next year was in order and in behalf of the Leon and Gadsden counties Medical Society extended an invitation to the Association to meet in Tallahassee and suggested the time of meeting be placed for the first week in April or as soon thereafter as possible.

Dr. John McDiarmid of DeLand extended a hearty invitation for the Association to hold its next annual meeting in DeLand. A ballot was taken which resulted in DeLand receiving 25 votes and Tallahassee 22 votes. DeLand was declared the choice for the

meeting place of the next annual meeting of the Association. Dr. John McDiarmid of DeLand thanked the Association for the honor conferred by selecting DeLand and assured all present that they would be given a most cordial and hearty greeting.

In accordance with the constitution it was announced that the time of meeting would be the second Wednesday in May.

The election of Councillors to take the place of those whose terms have expired or who had resigned from office or who for any reasons were disqualified from serving, with the time of expiration of office, resulted as follows:

First District—Dr. J. Harris Pierpont, Pensacola, 1917.

Second District—Dr. Henry E. Palmer, Tallahassee, 1917.

Third District—Dr. C. S. Brown, Live Oak, 1917.

Fourth District—Dr. Gerry R. Holden, Jacksonville, 1918.

Seventh District—Dr. David Forster, New Smyrna, 1918.

Eighth District—Dr. J. H. Hodges, Gainesville, 1918.

Eleventh District—Dr. W. R. Warren, Key West, 1918.

Moved by Dr. E. W. Warren and seconded that the Committee on Legislation and Public Policy get out a perfected bill to be presented to the legislature; that the Association give this committee official authority and that copy be printed and mailed to the county secretaries. Carried.

Moved by Dr. J. H. Hodges and seconded that the Committee on Legislation and Public Policy draw a bill for presentation at the next legislature to authorize the counties to levy a mileage for the erection and maintenance of county hospitals. Carried.

Moved and seconded that the name of the Leon County Medical Society be changed to the Leon-Gadsden County Medical Society. Carried.

It was moved by Dr. J. H. Pierpont and seconded that the estate of J. D. Fernan-

dez be paid six months salary for his services as Secretary of the Association and that the other six months salary be paid Dr. James D. Pasco for his services since assuming the office. Carried.

Upon motion the Association then adjourned.

The House of Delegates convened at 2 p. m., Dr. F. Clifton Moor in the Chair. The roll call of the Delegates was ordered and a quorum declared present.

It was moved and seconded that Dr. W. W. McDonnell be seated as a Delegate from Duval county in the place of Dr. Graham E. Henson, elected Secretary. Carried.

The Chair stated that the discussion of the report of the special committee appointed to act with the Standing Committee on Legislation and Public Policy in reference to plans for increasing membership of the Association and to consider the establishing of a State Medical Journal was the first order of business.

It was moved and seconded that no member of the House be allowed the floor on this discussion more than once and that his time be limited to five minutes. Carried.

After considerable discussion it was moved by Dr. Glover and seconded that the Association adopt the report of the Committee on Legislation and Public Policy providing for a field secretary and further that the Association authorize the publication of a State Journal, provided, however, that the Journal be limited to an appropriation of \$600. The motion was lost by a vote of 38 nays to 9 ayes.

Moved by Dr. Pierpont and seconded that the State Association adopt the report of the special committee appointed for the purpose of investigating and reporting upon the most advisable course to pursue to increase the membership of the organization and the advisability of establishing the State Medical Journal; provided further, that the Association appropriate the sum of \$800 toward the maintenance and support of a State Medical Journal. Carried.

Moved by Dr. J. H. Pierpont and seconded that the President be authorized to confer with the Publication Committee with a view of ascertaining the revenue secured from the advertising pages of the State Medical Journal and that if this revenue is sufficient to warrant a further expenditure, the Association place a secretary in the field for the purpose of soliciting members for the Association. Carried.

The Chair stated that he would entertain a motion providing for the election of a Delegate to the House of Delegates of the American Medical Association.

Dr. John McDiarmid of DeLand was placed in nomination and there being no further nominations, it was moved and seconded that the Secretary cast the ballot of the Association for Dr. McDiarmid. Carried. The Secretary cast the ballot.

Upon motion duly seconded Dr. John E. Boyd of Jacksonville was declared the alternate to the House of Delegates of the American Medical Association.

It was moved by Dr. J. H. Pierpont and seconded that an appropriation of \$100 or whatever proportion necessary be allowed to pay the expenses of the Delegate to the Atlantic City meeting of the American Medical Association. Carried.

The committee appointed to audit the books of the Secretary and Treasurer reported as follows:

To the House of Delegates of the Florida Medical Association:

GENTLEMEN—Your committee appointed to audit the reports of the Secretary and Treasurer find that all accounts are correct.

GRAHAM E. HENSON, M. D.

JOHN MCDIARMID, M. D.

A. C. HAMLIN, M. D.

Moved and seconded that the report be accepted and placed on file. Carried.

The following amendments to the Constitution, introduced by Dr. J. Harris Pierpont at the Miami meeting and in accordance with the Constitution held over a year,

were read by the Secretary and, upon motion duly seconded, adopted:

That Article VIII, Section 2, be amended to read: The President and Vice-Presidents shall be elected for a term of one year. The Secretary, Treasurer and Councilors shall be elected for a term of four years each, the Councilors being divided into classes so that three shall be elected each year, for three years, and two for the fourth year. All of these officers shall serve until their successors are elected and installed.

That Article VIII, Section 3, be amended to read: The officers of this Association shall be elected by the Association on the morning of the second day of the Annual Session, and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such an office who is not in attendance on that annual session (except the Councilors), and who has not been a member of the Association for two years.

Committee on Resolutions offered the following:

Resolved, That the Florida Medical Association in convention assembled herewith tender their thanks for courtesies extended to the Orange County Medical Society, the city of Orlando, the Elks Club, the local press and all others who have been so kind to make our visit to Orlando so pleasant and profitable.

M. B. HERLONG, M. D.

R. H. MCGINNIS, M. D.

E. W. WARREN, M. D.

Moved and seconded that these resolutions be adopted by a rising vote. Carried.

The House of Delegates then adjourned *sine die*.

The scientific program was resumed under the chairmanship of Dr. Gerry R. Holden.

The following papers were read and discussed:

"Pathological Vaginal Discharges," by Dr. T. S. Field, of Jacksonville.

"Caesarean Section," by Dr. C. L. Jennings, of Jacksonville.

"Cystitis, a Symptom," by Dr. J. C. Vinson, of Tampa.

"Acute Inflammation of the Pelvic Organs," by Dr. G. R. Holden, of Jacksonville.

"The Abuse of the Curette," by Dr. J. K. Simpson, of Jacksonville.

"Should the Physicians Dispense His Own Remedies?" by Dr. A. H. Freeman, of Starke.

"The Treatment of Drug Addictions," by Dr. M. B. Herlong, of Jacksonville.

"Directions," by Dr. U. S. Bird, of Tampa.

"Facial Paralysis Occurring in the Course of Treatment of Syphilis," by Dr. J. L. Kirby-Smith, of Jacksonville.

The meeting then adjourned until 9 p. m., it being announced that the program would be concluded at the Country Club.

The Association reconvened under the chairmanship of Dr. Gerry R. Holden, following a banquet at the Country Club, when the following papers were read and discussed:

"Sandspur in the Larynx, Its Removal, With Report of Two Cases," by Dr. C. D. Christ, of Orlando.

"The Karell-Kur," by Dr. Thomas Truelsen, of Tampa.

"The Diagnosis and Treatment of Venereal Ulcers," by Dr. W. P. Dey, of Jacksonville.

"Toxaemia, Some Points in Etiology and Symptoms With Deductions," by Dr. C. J. Roehr, of Ft. Pierce.

The General Association then adjourned *sine die*.

THE TREATMENT OF AMEBIC DYSENTERY WITH EMETINE.—Emetine is a specific in the treatment of amebic dysentery. It is quickly absorbed and its effect is rapid and striking. It produces no unfavorable symptoms such as nausea, vomiting and depression.

Other forms of dysentery are not favorably influenced by this remedy, so that its employment as a diagnostic measure is of the greatest value.

Recurrences after apparent cure are not infrequent. It is therefore best to treat all cases showing a tendency to relapse intermittently with emetine.—Julius Friedenwald, M. D., in *New York Medical Journal*.

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, 334 St. James Building, Jacksonville, Fla., U. S. A.

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COUNCILLORS.

First District—Escambia, Santa Rosa and Walton Counties: J. Harris Pierpont, M. D., Pensacola. 1916

Second District—Franklin, Gadsden, Jefferson, Leon, Liberty and Waukulla Counties: Henry E. Palmer, M. D., Tallahassee 1917

Third District—Columbia, Hamilton, Madison, Lafayette, Suwanee and Taylor Counties: C. S. Brown, M. D., Live Oak 1917

Fourth District—Duval, Clay, Nassau and St. Johns Counties: Gerry R. Holden, M. D., Jacksonville. 1918

Fifth District—Citrus, Hernando, Lake, Marion and Sumter Counties: H. C. Dozier, M. D., Ocala. 1915

Sixth District—Hillsborough, Pasco and Pinellas Counties: U. S. Bird, M. D., Tampa. 1915

Seventh District—Brevard, Orange, Osceola, St. Lucie and Volusia Counties: David Forster, M. D., Hawks Park P. O., New Smyrna. 1918

Eighth District—Alachua, Baker, Bradford, Levy and Putnam Counties: J. H. Hodges, M. D., Gainesville 1916

Ninth District—Calhoun, Holmes, Jackson and Washington Counties: J. S. McGeachy, M. D., Chipley. 1918

Tenth District—DeSoto, Lee, Manatee and Polk Counties: Y. E. Wright, M. D., Wauchula. 1916

Eleventh District—Dade, Monroe and Palm Beach Counties: W. R. Warren, M. D., Key West. 1917

Next Meeting—DeLand—May 12-14, 1915

ANNOUNCEMENT.

At the forty-first annual meeting of the Florida Medical Association, held in Orlando last May, it was decided to publish monthly a State medical journal. This step was taken as a direct result of the report of a special committee appointed at the fortieth annual meeting held in Miami the year previous. The report of this committee, whose work was most painstaking and complete, appears in the transactions of the society published in this issue. The main object in launching this publication is to stimulate the interest of the profession in the State in organized medicine in general and the State society in particular. That stimulus is needed is self evident from the facts that with 1,177 physicians in the State there are but 238 fellows of the American Medical Association and 474 members in the State organization.*

But to increase interest in organized medicine is not the only field for this or other State journals. As each section of the country has its own medical problems to meet, so also has each State; Florida has her problems to solve and we believe that THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION will assist her in doing so.

In making our advent in State medical journalism we extend greetings to the medical press in general and especially to those State journals who have entered the field ahead of us and who have been carrying on a good work for some years past.

AN APPEAL FOR MEDICAL LEGISLATION.

The discussion of medical legislation is especially apropos in this, the first issue of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, for the simple reason that Florida has the most inadequate medical laws of any State in this country. A perusal of Dr. J. H. Pierpont's article read before

*The membership is now 500.

our annual meeting in Orlando, and published in this issue, will be worth while.

Medical practice acts are in a large proportion of instances the playthings of legislators, lawyers and courts. They are amended by legislators at discretion; argued into "innocuous desuetude" by lawyers, and ruled by courts on technicalities into meaningless and ineffective documents.

The regular medical profession has, by its untiring energy, example and precept, advanced the science of medicine beyond the stage of empiricism, mysticism, charlatanism and incantations and is continuing its philanthropic endeavors towards the education of the laity to a realization of its importance as a disease "eliminator," "health restorer" and above all a disease preventer. In other words, as a body of individuals with altruistic instinct and teaching, trying all in their power to put the profession itself out of business.

There is no nobler class than the medical fraternity and with united effort, constant vigilance and everlasting work we may in the no distant future convince the general public that legislation we advocate for ourselves is a benefit to it; and in raising the standard of education, medical knowledge, scientific attainment and qualifications for the practice of medicine in our own ranks make the achievements in our special line of work more efficient.

Let every medical man in the State exercise that influence, which is his by virtue of his training, to bring to a successful issue the passage of a working, efficient and just medical practice act that the people of Florida—our people, our friends—may be protected from charlatanry, quackery and fraud.

OUR ADVERTISING POLICY

With the initial efforts put forth by THE JOURNAL to secure advertising patronage it was decided to maintain a policy upholding the standard set by the Council on Phar-

macy and Chemistry of the American Medical Association. We believe that this is not only a proper but a wise course to pursue. The time is soon coming, we hope, when no reputable medical publication will advertise the wares of charlatans and quacks.

We wish to call the attention of our readers to the fact that a medical journal to be successful must secure advertising patronage, and that to hold it the advertiser must be satisfied he is making a good investment in the money paid out for advertising. So we urge that, in so far as their interests will allow, our readers patronize those who are assisting in the publication of our State journal. Not only this, but when they do so let it be known to the advertiser that he is reaping the benefits of bread cast upon the waters.

THE ATLANTIC CITY MEETING.

The sixty-fifth annual meeting of the American Medical Association was formally called to order in the Apollo Theatre, Atlantic City, the morning of June twenty-third, by the President, Dr. John A. Wither-
spoon, of Nashville, Tenn.

The total registration during the session exceeded three thousand and represented every State and territory in the Union. A feature of the opening session was the presentation of a gold medal to Surgeon General W. C. Gorgas, of the United States Army, a gift from the American Medical Association in recognition of his achievements in preventive medicine in connection with the building of the Panama Canal. The full success of the meeting is well portrayed by stating that in the House of Delegates, with an entitled representation of 140 members, there were only seven absentees. Too much praise cannot be given to the Committees on Arrangements and Entertainment. The minutest details had been carefully provided for and it is safe to say that those who were in attendance at the meeting were provided with a feast of sci-

entific matter which, combined with the several entertainment features, was such as to impress them when they left Atlantic City

with the fact that it had been their privilege to attend the most successful meeting in the history of a truly great organization.

Review of Current Literature

SURGERY.

RADIUM IN CANCER

Janeway (*J. A. M. A., Vol. LXII, No. 22*) reviews results obtained in various clinics and radium institutes from the use of radium in cancer. He quotes Wickham's summary as follows:

1. Radium causes an undeniably destructive modification of the malignant cells.

2. Malignant tissues display a special and very selective susceptibility to the influence of radium.

3. This destructive action extends to a depth varying up to 9 cm., according to the dosage used and the sensitiveness of the neoplasm.

4. This action, even in the depth mentioned, occurs with the maintenance of the relative integrity of the normal tissues transversed.

5. The action, nevertheless, is not complete enough to warrant the use of radium as a primary therapeutic agent in any form of operable cancer, with the single exception of cancer of the skin.

He particularly emphasizes the fact that radium has proven to be uncertain and usually ineffective in deep-seated cancer and "while it will destroy cancer tissue in a dosage not affecting normal tissues, it does not cure the disease unless it is quite superficial or of the varieties peculiarly susceptible to its influence." He further states: "Each report justifies the statement that radium produces a selective destructive action on the majority of cancers, but that this action never reaches to the more distant extensions of its deeper and more serious forms. Indeed, there is good ground for belief that unless the greatest care is used in the application of radium, the more dis-

tant portions of the tumor will be stimulated to more active growth. All observers of the action of radium on cancer have expressed the belief that an insufficient dosage of radio-activity may stimulate tumor growth."

There seems no doubt that early operation followed by the use of radium or the X-ray offers the greatest, indeed in most sarcoma and carcinoma the only hope for complete cure—radium alone, except in skin or superficial cancer, "may only supplement but not replace the knife."

EARLY RECOGNITION OF CANCER

Joseph Bloodgood (*Public Address*, 1914) continues the appeal for the early recognition and treatment of cancer, and emphasizes the fact that cancer is, in many instances, a preventable disease.

"Every one is duly warned. Those who are educated to this warning and those who heed the warning will be rewarded. Cancer never begins in a healthy spot. In external cancer the warning is always something first to be seen with the eye, or felt with the finger. These first signs are warts, moles, little areas covered with a scab, or an unhealed wound, or there may be a little lump or nodule beneath the skin, or deeper. Pain is rarely present. Unfortunately many people have frequently observed all of these things which have either disappeared, or remained unchanged for years. They remember these cases, but do not realize the great number of unfortunates in whom cancer has developed from such apparently innocent skin defects or nodules beneath the skin. It may be truthfully stated that external cancer is a disease which develops under ignorance, skepticism or procrastination, be-

cause of entirely needless fear of an operation. It is not for the patient, but for the physician to decide whether these visible and palpable abnormalities are to be left alone or removed."

"Cancer of the uterus. There is every reason to believe that cancer of the uterus could be placed among preventable diseases. There is always a discharge of a different character at a different time and for a longer period than normal."

"Cancer of the breast. In a woman over twenty-five the finding of a lump in the breast should be considered a definite warning. If this lump is subjected to treatment at once the chances are fifty per cent that it is not cancer. In such a fortunate event it is only necessary to remove the lump. When the surgeon at his operation finds that the lump is cancer the chances are one out of four that it is the least malignant form of cancer, in which the probabilities of a cure are one hundred per cent."

"Cancer of the lip and tongue. Every man is warned in time; there is always first to be seen and felt on the lower lip or on the tongue some abnormal defect. This defect is often a burn from smoking, or an irritation from ragged teeth. When men heed this warning and receive treatment within a few weeks the probabilities of a cure are one hundred per cent."

"In cancer of the skin, lip and tongue the operation in this earliest stage should accomplish a cure in one hundred per cent of cases. The operation is a simple one; it can usually be performed under local anaesthesia. There is no danger. There will be no mutilation."

"The operation for cancer of the breast is neither serious nor dangerous, nor is the operation for cancer of the uterus."

"Few people realize that operations for cancer of the stomach, colon and kidney are by no means dangerous. The failure to cure is due to delay, not to surgery."

"A majority of surgeons today believe that when cancer has advanced to a point

where a positive clinical diagnosis is possible, that it is too late to cure by surgical or other means, and further, that after cancer of uterus, stomach, breast or tongue has fully developed, whether diagnosis is possible or not, that absolute cure by any means whatsoever is uncertain if not impossible. The time to operate on breast cancer is in the benign tumor stage which precedes cancer, on the stomach in the pre-cancerous ulcer stage, on the uterine cancer in the primary stage of benign laceration, inflammation, and ulceration. In a word, when the case has progressed to a point where the physician may say, 'This is cancer,' it is too late.

"Cancer always begins in a single spot, and in that spot there is always first something that is not cancer. There is always an interval between the first warnings and the development of cancer. There is always an interval between the development of cancer and its spread from that spot. In a few instances the interval may only be a few weeks, in others months, in many years. No one can tell this interval. Delay, therefore, is gambling with death."

MEDICINE.

CONSTIPATION AND ITS TREATMENT.

In the *New York Medical Journal*, Vol. XCIX, No. 22, Max Einhorn, writes on "Habitual Constipation and its Treatment." He considers that under the term "habitual constipation" may be included all cases of retarded bowel movement in which there is no severe organic lesion or stricture. He discusses the theory originated in France that as a result of "habitual constipation" poisons developed in the intestinal tract, producing an autointoxication. He considers that this theory, which in his mind has been very much exaggerated, has worked considerable harm, producing nervous conditions in many individuals which worried them to the point of despair, causing anxiety and fear concerning the poisons they believed to exist in their systems. He

considers these nervous symptoms are not produced by intoxication but that on the other hand they are the direct cause, in many cases, of severe constipation. In discussing the etiology of constipation he lays especial stress on the failure of taking proper time each morning for a bowel movement, calling attention to the fact that this type of constipation is more prevalent in cities, among the more highly civilized, than in the rural communities. Another etiological factor is a rigid diet without fruit, potatoes and in some cases, all solid food, the patient living on liquid diet and with such little food residue as to prevent proper peristalsis. He questions the correctness of the theory that constipation may be due to an abnormal condition of the large bowel, to a kink, a ptosis or a too long colon, calling attention to the fact that Leichtenstern found this theory did not hold good in autopsies, in which anomalies existed in regard to the position of the colon. He also discusses Schmidt's theory of constipation being due to a better process of digestion and assimilation resulting in a too small amount of residue being left undigested to produce efficient peristalsis for the normal bowel movement. In discussing the theory of autointoxication he lays considerable weight on the fact that constipation artificially produced by opiates does not produce dizziness, headaches and other phenomena attributed to constipation. In considering the treatment of this condition he lays considerable stress on assuring the individual that it is not necessarily a serious condition and urges the formation of regular habits for the morning stool, suggesting in the lack of a desire that the same time be observed each morning, but cautions against any great amount of strain, which is liable to bring on hemorrhoids. In treating from the dietetic standpoint he advocates the giving of bulky foods, fruits and salads and vegetables which contain a large proportion of cellulose. He further discusses the administration of agar, as advocated by

Schmidt, and reports successful results from the use of a preparation of 3 per cent phenolphthalein and agar in teaspoonful doses three times a day. He further discusses massage of the bowel, electricity and hydrotherapy and concludes by stating, "Try one thing and then another and if the patient is not in a hurry it is nearly always possible to relieve the conditions in the measures above described."

GYNECOLOGY.

CÆSAREAN SECTION FOR ECLAMPSIA.

Reuben Peterson presents an interesting study in the *American Journal of Obstetrics*, June, 1914, under the title, "A Critical Review of 500 Published and Unpublished Cases of Abdominal Caesarean Section for Eclampsia."

These cases, the details of which Peterson has analyzed, represent the work of 259 operators in various parts of the world. One hundred and thirty-one were operators from the United States. In five years, from 1908 to 1913, the maternal mortality was 25.79 per cent. In the earlier cases it was over 47 per cent. Therefore the old figures of a maternal mortality of from 40 to 50 per cent are incorrect and should no longer be quoted. Also it is probable that in the future the mortality percentage of 25.79 per cent can be considerably lowered by care in technic and better selection of cases.

Convulsions ceased after operation in 54.92 per cent. There was, however, a maternal mortality of 19.8 per cent in 146 cases in which the convulsions ceased after operation. This death rate is much less still than in the cases in which convulsions continue after operation. In 130 such cases there was a maternal mortality of 31.53 per cent.

To obtain the best results the uterus should be emptied quickly, as soon as possible after the onset of the first convulsion. Good results are not likely to be obtained

after the woman has been infected by frequent vaginal examinations or attempts from delivery from below. Inasmuch as the fetus is affected by the eclamptic poison as well as the mother, the fetal mortality is much less in those cases in which operation is done early.

Excluding the premature children and counting as living all children who survived one hour, the fetal mortality was 3.62 per cent. Counting as deaths all children who died in the first three days, the fetal mortality is 10.69 per cent. This fetal mortality, Peterson states, is much less than that obtained in any other method of treating eclampsia.

In 474 patients 83.75 per cent were primiparae and 16.17 per cent multiparae. The large proportion of primiparae is probably accounted for by the fact that primiparous conditions (*i. e.*, undilated cervix, rigidity of cervix and small parts, etc.) made laparotomy necessary more frequently than in multiparae. In primiparae the mortality was 24.44 per cent. In the multiparae it was 27.08 per cent.

The fetal mortality was higher in multiparae also. The average age in multiparae is greater than in primiparae, therefore the toxæmia of the children is greater and hence the higher death rate. The maternal mortality also steadily increases with the age of the patient. The maternal mortality decreases with the advance of pregnancy. It is higher in those cases which are not at full term.

With the present state of our knowledge of the results of abdominal Caesarean section for eclampsia it cannot be denied that the older methods are better in cases with normal pelvis and soft parts. But with a maternal mortality of 18.68 per cent in one series of 191 cases, 13.13 per cent in a second series of 76 cases, and 15 per cent in 60 cases in which the uterus was emptied after a few convulsions, this procedure, states Peterson, has reached a stage where it can no longer be disregarded by obstetricians

who have based their objections to it upon statistics which were altogether too high.

PEDIATRICS.

ACID INTOXICATION IN INFANTS.

Concerning this subject an instructive article appeared by Isaac A. Abt, (*Am. Journal Medical Sciences*, 1914, I) which should be of particular interest to Southern physicians. He reports a number of cases which closely resemble the clinical type usually referred to as intestinal infections. Acid intoxication of the kind referred to by Dr. Abt is usually found about the end of the lactation period and among infants previously healthy. The symptom complex being vomiting, a certain amount of diarrhoea, prostration, rapid and labored respiration and usually death within from two to four days of the onset. There is always marked enlargement of the liver. The author believes the disease to be due to a metabolic disturbance rather than to bacterial infection. This faulty metabolism results in misdirected chemical processes with the consequent production of toxic products.

These toxic products, which are of chemical rather than bacterial origin, produce extensive granular and fatty degeneration of liver and kidney cells. Probably these destructive changes have insidiously proceeded before marked symptoms of illness appear. If the cellular degeneration is sufficiently extensive, and it usually is, death seems to be inevitable. The cause of this faulty metabolism is not given; while acetone usually appears in the urine he regards acidosis as being an inconsequent result of the causative chemical processes.

STUDIES IN CARDIAC STIMULANTS.

Writing on this subject, William Palmer Lucas (*Am. Journal Diseases of Children*, 1914, III) mentions the fact that in none of the German text books is strychnin mentioned as a heart stimulant. That it is only

in America and England where it is extensively employed for this purpose.

The author's opinions were based on the results of wide study and investigation with special reference to the employment of heart stimulants in childhood. He concludes that strychnin can not be considered as a cardiac stimulant in any therapeutic manner. He agrees with Dr. Sollmann that "strychnin should not be used in heart disease" for if it has any action it increases the work of the heart."

He also quotes Dr. R. C. Cabot, who, after giving strychnin in daily doses of $\frac{1}{8}$ to $\frac{1}{6}$ grain in cases of typhoid fever, says: "I have been unable to convince myself that strychnin exerts any influence on the blood pressure in febrile cases when given in the doses as mentioned."

The author could observe no effect from the employment of caffein in ordinary therapeutic doses. His conclusions are "strychnin and caffein in the doses usually used for cardiac stimulation are of no value."

SILVER NITRATE SOLUTION IN THE TREATMENT OF WHOOPING COUGH.

The New York Medical Journal abstracts an article from Ochsenius in *Semaine Médicale*, November 26, 1913, in which the author makes mention of one hundred and seven cases of pertussis which were treated with decidedly beneficial result by the application to the pharynx of a two per cent solution of nitrate of silver. The author recommends that the treatment be begun within two weeks after the beginning of the disease, before the lower respiratory passages have become involved. He claims that the silver salt either destroys the virus or diminishes the secretion of mucus, thereby reducing the frequency of the paroxysms. Beneficial results are noted after a week's treatment. The applications are energetically made to the pharynx by means of cotton wound around an applicator which is bent to a right angle. The treatment is

repeated on alternate days for two weeks, though occasionally treatment is demanded for an additional week.

In some cases a one per cent solution of silver salt is preferable to the two per cent solution.

On the days following the applications a slight increase in the number of paroxysms may be observed.

Ochsenius also found that morning and evening nasal irrigations with a 0.5 to one per cent solution of hydrogen dioxide were distinctively effective through diminishing secretion of mucus in the nasopharynx.

MEDICAL ASPECTS OF THE TREATMENT OF PYLORIC STENOSIS IN INFANTS.

This subject was freely discussed before the New York Academy of Medicine and reported in *The Journal A. M. A.*, June 13, 1914. Dr. L. Emmett Holt reported fifty-seven cases, twenty-eight of which were treated surgically and twenty-nine medically. The entire mortality was 55 per cent, it being slightly higher in those treated medically.

He considers as indications for operative treatment (1) no diminution of the vomiting or gastric peristalsis by stomach washing and diet; (2) a steady loss of weight of one or two ounces a day; (3) marked gastric retention; and (4) absence of fecal stools. He regrets that operation was delayed in so many of his cases and in some was not done at all. He deplors persistence in medical treatment when forcible vomiting and marked peristalsis show no abatement; as it seems to him that greater risk is incurred by a continuance of conservative treatment than by operative measures.

DERMATOLOGY AND SYPHIL- OLOGY.

SALICYLIC ACID AND ZINC OXIDE PLASTER IN THE TREATMENT OF SMALL SKIN CHANCERS.

In the March number of the *Muench. Med. Wochenschr.*, Weinbrenner reports

good results from treating small neoplasms with salicylic acid and zinc oxide plaster, applied over the whole growth to be treated, the dressing being renewed every third day until the mass becomes necrotic. The writer reports nine cases treated by this method, all of which were cured.

CHANGE OF CLIMATE AND HIGH ALTITUDE IN THE TREATMENT OF PELLAGRA.

In the June number of the *Southern Medical Journal*, R. E. Sylvester, of Tyler-town, Miss., gives a very interesting account of the treatment of Pellagra at Colorado Springs, Col. The treatment was purely symptomatic and dietetic, combined with absolute rest; arsenic in the form of the cacodylate of soda was given in full doses; Dr. Sylvester gives his experience from the observation of the successful treatment of thirty-five pellagrins including himself as a patient.

ATTEMPTED CULTURES IN A CASE OF LEPROSY UNSUCCESSFUL.

Ervine and Larsan, of Minneapolis, report in the June *Interstate Medical Journal* an unsuccessful attempt at growing cultures of the lepra bacillus from a clinically well developed lepra case. Injections of salvarsan were given and some improvement noted in the character of the lepra lesions; the Wasserman reaction before treatment was negative and two weeks after the second salvarsan injection the reaction became positive. There was no explanation given for this interesting change in the patient's serum.

EXTERNAL VACCINE THERAPY.

At the recent meeting of the American Dermatological Association, H. P. Towle, of Boston, made a report on his observation of the treatment of one hundred and fifty private dermatological cases with external vaccine therapy. Dr. Towle thinks this procedure compares favorably to the

method of subcutaneous injection of vaccines.

INJECTION OF CONCENTRATED SOLUTIONS OF SALVARSAN AND NEOSALVARSAN.

A. E. Taussig in the June *Interstate Medical Journal* gives a summary of the recent literature on the concentrated method of salvarsan and neosalvarsan therapy and gives the following conclusions: "1. Concentrated solutions of salvarsan or neosalvarsan minimizes or does away with the ill effects due to imperfect distilled water.

"2. No apparatus is required other than a syringe for neosalvarsan or a syringe and a small glass vessel for salvarsan, the use of plain distilled water or tap water possibly in place of the salt solution is another simplification.

"3. The new method is not only a saver of time, but the use of an assistant can be dispensed with.

"4. For nervous patients the intravenous injection of a syringe-ful of medicine is a procedure less taxing than the slow infusion of a large quantity.

"5. There is reason to believe that concentrated solutions are more effective than dilute ones, in that salvarsan in the former case is more slowly excreted.

"6. Objection to the new method is that the imperfect intravenous injection will be followed by most profound local reaction."

RETRODISPLACEMENTS OF THE UTERUS.—Retroversion after confinement occurs much more frequently than is generally supposed. It can often be prevented by simple routine measures.

Patients should be examined more frequently during the puerperium, and hospital patients should be instructed to return for an examination in about a month after their discharge. I have already adopted this rule in the service at the Manhattan and at Bellevue.

When retroversion does occur, treatment should be begun at once. The results of treatment which is begun early, while the uterus, including its ligaments, the vagina and pelvic floor, are still subinvolved, may be said to be universally good if we leave out cases in which the retroversion is simply a recurrence of a condition existing previous to pregnancy.—Austin Flint, Jr., M. D., in *The American Journal of Obstetrics and Diseases of Women and Children*.

ASSOCIATION NEWS.

The President announces the following committee appointments for the ensuing year:

Committee on Legislation and Public Policy:

Dr. E. W. Warren, Palatka.

Dr. J. H. Pierpont, Pensacola.

Dr. C. M. Ansley, Tallahassee.

Committee on Publication:

Dr. G. E. Henson, Jacksonville.

Dr. A. H. Freeman, Starke.

Dr. R. H. McGinnis, Jacksonville.

Committee on Scientific Work:

Dr. R. N. Green, Chattahoochee.

Dr. J. C. Vinson, Tampa.

Dr. Wm. S. Manning, Jacksonville.

The Committee on Legislation and Public Policy will meet in Tallahassee on July 22d to complete the draft of a medical practice act.

NEWS ITEMS.

The State board of regular examiners held their biannual meeting in Palatka, June 16th and 17th. There were ninety-seven applicants before the board during this meeting. The report of the secretary of the board will appear in the next issue of THE JOURNAL.

While on a visit in the Eastern States and in attendance at the meeting of the American Medical Association in Atlantic City, Dr. J. Y. Porter, our genial State health officer, was taken seriously ill and confined to his bed for a number of days; for awhile his condition was quite critical, but THE JOURNAL is pleased to state that Dr. Porter has returned home and is making a good recovery.

Dr. C. C. Collins, who for some time past has been the senior resident physician of St. Luke's hospital, Jacksonville, is receiving congratulations from his friends, who are legion, upon his marriage to Miss Belle Francis, who has also been connected with St. Luke's hospital for a number of

years. Dr. and Mrs. Collins, after a brief wedding trip, took up their residence in Jacksonville, Dr. Collins having recently associated himself with Dr. Frederick J. Bowen.

Dr. John McDiarmid of DeLand, after attending the Atlantic City meeting of the American Medical Association, where he represented the State in the House of Delegates, is making a tour of the Eastern States in his automobile. Dr. McDiarmid is expected to return to Florida at an early date.

Dr. Frederick J. Waas of Jacksonville, after spending a short time attending the clinics in Chicago and the Mayo clinic in Rochester, was in attendance at the Atlantic City meeting of the American Medical Association. He returned home the first of the month.

Florida was well represented at the sixty-fifth annual session of the American Medical Association, held in Atlantic City last month, the following gentlemen registering during the session: Lewis DeM. Blocker, Pensacola; John McDiarmid, DeLand; Joseph W. Taylor, Wauchula; James W. West, Live Oak; G. H. Benton, Miami; John W. Hodges, Green Cove Springs; B. F. Hodgson, Miami; Fred J. Walters, Daytona; Joseph Y. Porter, Frederick J. Waas, Graham E. Henson, Wm. S. Manning and C. E. Terry, Jacksonville, and W. A. Wright, Pocatello.

During the illness of Dr. J. Y. Porter, State health officer, Governor Park S. Trammell appointed Dr. S. R. M. Kennedy of Pensacola to serve in the capacity of Acting State Health Officer. This action was deemed advisable owing to the appearance of bubonic plague at New Orleans.

Drs. Frederick J. Bowen and Walter P. Dey of Jacksonville sailed from New York on the 17th inst. for London, where they will attend the Clinical Congress of Surgeons. They will return to Jacksonville early in October.

Dr. J. E. Mains of Lake Butler was a visitor to Jacksonville during the month.

Dr. R. P. McFeeters of Dowling Park was in Jacksonville attending to professional and business matters during the past month.

Dr. F. W. Wilcox of St. Petersburg left last week for his summer home in Chautauqua. Dr. Wilcox will return to St. Petersburg early in October.

For the first time since the epidemic in California bubonic plague has made its appearance on our shores. Some two weeks ago a case was recognized in New Orleans and promptly reported to the State and Federal authorities. Upon request of the authorities in New Orleans Surgeon General Rupert Blue of the United States Public Health Service, after making a preliminary investigation, assumed entire charge of a campaign to prevent further spreading of the disease. A vigorous campaign of rat extermination is planned, the legislature making a suitable appropriation to carry on the expenses of the campaign. As THE JOURNAL is going to press a second focus of infection is reported in New Orleans, but it is now believed, with the vigorous steps instituted by Surgeon General Blue, that the disease will not gain a foothold in this country. Steps have been taken by other coast towns, including Jacksonville, to inaugurate a campaign of rat extermination.

J. D. FERNANDEZ, M. D.

While it is now several months since the demise of Dr. J. D. Fernandez, for many years the Secretary and Treasurer of the Florida Medical Association, it seems especially fitting that some mention be made of his life work in this, the first issue of THE JOURNAL. A native son of Florida, as was his father before him, from the time of entering the medical profession in 1870, he was untiring in his efforts for the welfare of the profession in the State and for

organized medicine. It was largely through his efforts that the Association successfully passed an era in which disorganization was threatened. Loved by all who knew him his loss is keenly felt throughout the entire State. The following resolutions passed by his home County Medical Society reflect the sentiment of all who came in contact with him:

WHEREAS, Death has removed from our midst and the scene of his professional activity our esteemed and respected colleague, Dr. J. D. Fernandez, and

WHEREAS, We are mindful of many obligations which we, as physicians of Jacksonville, have incurred through his precept and example, and sincerely appreciating the work of this pioneer of medicine and surgery which has served as a stimulus to the performance of much of the best and most creditable work that has been accomplished in this community, and

WHEREAS, For many years we have recognized Dr. Fernandez as a power for the promotion of good, as a man unswerving in his devotion to his profession and to all that concerned the welfare of the people of his State, as a man of rugged and sterling honesty, a true exponent of professional ethics, a man imbued with lofty ideals and pure conceptions of duty to humanity and to his profession, and

WHEREAS, His ability as an organizer, his widespread popularity and his unflinching efforts in behalf of the profession of medicine have contributed largely to the up-building and sustaining of organized bodies of physicians throughout Florida, and

WHEREAS, His rare accomplishments in medicine and surgery, his loyalty and zeal in the enactment of principles deemed by him for the betterment of humanity have imbued us with feelings of profound reverence and respect; be it

Resolved, That as members of a profession which has been graced and made better by Dr. J. D. Fernandez, and as members of a society which in a large measure owes its

existence to his persevering efforts, we acknowledge our indebtedness for the example set us,

Resolved, That the Duval County Medical Society, the profession of Florida and the people of this community have, in the death of Dr. J. D. Fernandez, sustained a loss that is irreparable; that the memory of his noble character, his charity and forbearance will be an incentive to us to perpetuate the good work he conceived and fostered,

Resolved, That we sincerely grieve his departure from our midst; that a copy of these resolutions be spread on the minute book of the Duval County Medical Society; and that a copy be sent, as a manifestation of our sympathy, to his sorrowing relatives.

(Signed) JAMES D. LOVE.

G. R. HOLDEN.

J. V. FREEMAN.

NEW AND NONOFFICIAL REMEDIES.

Since publication of *New and Nonofficial Remedies*, 1914, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New Nonofficial Remedies":

ELECTRARGOL.—Electrargol is a colloidal solution of silver, containing silver, equivalent to 0.25 per cent. metallic silver. It is said to be useful in febrile diseases, even in those which are not of a septic character. It is also used externally in inflammatory conditions. For subcutaneous, intramuscular or intravenous injections electrargol is supplied as Electrargol for Injection in ampoules containing 5 cc. For external use electrargol is supplied as Electrargol for Surgical Use in bottles containing 50 cc. (*Jour. A. M. A.*, June 6, 1914, p. 1808.)

REFINED AND CONCENTRATED TETANUS ANTITOXIN.—Marketed in packages containing 5,000 units (curative dose) put up in syringe containers. E. R. Squipp &

Sons, New York. (*Jour. A. M. A.*, June 13, 1914, p. 1890.)

CULTURE OF BULGARIAN BACILLUS, MULFORD.—A pure culture in tubes of the *Bacillus bulgaricus*. It is designed for internal administration for the purpose of establishing lactic-acid-producing bacilli in the intestines and for external use. H. K. Mulford Co., Philadelphia, Pa. (*Jour. A. M. A.*, June 13, 1914, p. 1890.)

LACTOBACILLINE TABLETS.—A pure culture of the *Bacillus bulgaricus*. These tablets give rise to the production of considerable quantities of lactic acid, which tends to restrain the growth of putrefactive organisms in the intestines. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1890.)

LACTOBACILLINE LIQUIDE, CULTURE A.—A pure culture in tubes of the *Bacillus bulgaricus* grown in a neutralized sugar bouillon, each tube containing from 5 to 6 cc. Its actions and uses are the same as those of Lactobacilline Tablets. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

LACTOBACILLINE LIQUIDE, CULTURE D.—A pure culture in tubes of the *Bacillus bulgaricus* grown in a neutralized bouillon. Its action and uses are the same as those of Lactobacilline Tablets. Marketed as Lactobacilline Liquide, Culture D., small, containing 5 cc., and Lactobacilline Liquide, Culture D., large, containing 16 cc. in each tube. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

LACTOBACILLINE GLYCOGENE LIQUIDE.—A pure culture in tubes of the *Bacillus bulgaricus* and the *Glycobacter peptolyticus*. Its action and uses are the same as those for Lactobacilline Glycogene Tablets. Marketed as Lactobacilline Glycogene Liquide, small, containing 5 cc., and Lactobacilline Glycogene Liquide, large, containing 16 cc. in each tube. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

JACKSONVILLE, FLORIDA, AUGUST 18, 1914

Number 2

ORIGINAL ARTICLES

QUACKERY, SUPERSTITION AND ROBBERY, ANCIENT AND MODERN, IN THE TREATMENT OF DISEASE.*

W. R. WARREN, M. D.,

Key West, Fla.

In attempting before you this talk, while I feel with concern how unequal my abilities are to my own wishes, or may be to your expectations, I trust to your indulgence.

Investigation of business and politics, with exposure of their evils that we know exist, now engages our attention to a marked degree; and since no department of science is hidden from those who have a desire to know—when medical subjects, medical journals and medical men are freely discussed and criticized—no apology is necessary if I endeavor to draw aside the professional veil, and admit light on questionable practices.

Mysticism and medicine in the past have been inseparable. The fact that they are not yet divorced is proven daily by the methods and manners of notorious quacks, nurses, and even licensed physicians.

The practice of medicine and surgery, in its broadest sense, has no mysteries and the true student and scientist have nothing to conceal.

The discoveries of medicines and arts, used in fighting disease, are hidden in the ancient past, for we read in Ecclesiasticus, XLIV Chapter, 9th and 10th verses:

"And some there be which have no memorial; who are perished, as though they had never been; and are become as though

they had never been born; and their children after them. But these were merciful men, whose righteousness hath not been forgotten."

No one man first discovered the medical herbs used in the early days, and no one man can now assimilate all the knowledge of disease and its treatment. It is the work of ages and hundreds of thousands of investigators.

Medical men have always occupied a prominent and honorable position in society, and it is our duty and privilege to see to it that this position is maintained by true service to you. You, in turn, must see to it that only true men are encouraged to serve you.

The intimate connection between magician, sorcerer, and medicine man—always found in the past—should not exist today; but the practices of the aborigines of Central Africa are quite as intelligent as some in vogue in our own communities.

A common belief among the uncivilized is, that disease is an evil spirit, and it arises naturally when they see an individual tossed by fever or writhing in convulsions, as if possessed of a demon. This belief is still present among the ignorant whites, and to a greater extent, among the negroes.

The past had its quacks. They were grave, sedate, cunning, and had sufficient knowledge of herbs and disease to make people stand in awe of them. Credulity and love of the marvelous are inherent traits which allow mankind to be easily duped by impostors—and instead of seeking a natural explanation of phenomena, attribute tempests and plagues to the anger of demons.

The first physicians among savages are conjurers who boast that they know the past

*Oration delivered before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

and can foretell the future; this pretense, however, is not confined to savages. How many of you here present have had your fortunes told? And more than you will admit sinks into your inner consciousness, when the palmist pretends to read wealth and happiness in the lines of your hand.

The individual, even today, who is in no way superstitious, is the great exception. Investigate the superstitions about Friday and the number thirteen. You may say it is idle fancy without significance, but the superstitions of mariners govern their actions to a considerable extent, and the same may be said of the whole human race to some degree.

Medical History dates back to the Egyptians, for they had some knowledge of anatomy, pharmacy, physiology, therapeutics and surgical bandaging, eight thousand years ago. They led the world in medical learning.

Practitioners of medicine in ancient Egypt, however, devoted themselves to magic and the interpretation of dreams. Our word chemistry is derived from Khem, the Egyptian god of curative herbs. Even now the Egyptians wear charms against disease, and swallow pieces of paper with inscriptions from the Koran, to cure their maladies.

Jewish Medicine is remarkably free from superstition. The descendants of that portion of the Hebrew race led by Moses from Egypt back to Palestine should be proud of the fact that among other nations and peoples of the earth, they stood unique and free from the degrading superstitions surrounding them. The purest theism took the place of witchcraft, sorcery, demonology and worship of many gods. Hence, the Bible is remarkably free from superstition and magic.

The Mongolian peoples, like most of the others, associated magic and sorcery with religious conceptions, which were inseparable from their medical history. The demon theory of disease still exists throughout the

Chinese empire, and bodily ills are believed to spring from the air or spirits. When sick, they pray to the god of the disease from which they are suffering, to banish the baneful influence under his control. The medical profession is a very crowded one in China. There is one check on quackery, however, for the Chinese have a special place in their second hell for incompetent physicians. The fourth hell is reserved for bad druggists.

One of the commonest diagrams to be met with in China is the mystic swastika, or Thor's hammer (卐). It is found on medicine wrappers and supposed to possess ten thousand virtues. We are not much better, however, with wishbones, amber beads, precious stones, *et cetera*.

Greek Medicine is intermixed with mythology, and begins with Apollo, the health-god, and father of Aesculapius. The snake-entwined staff of the healing-god, Aesculapius, is still used as a symbol of medicine, and the daughters Hygeia and Panacea, are personifications of the father's powers. The ancients everywhere believed that the healing art was taught mankind by the gods. Hippocrates, however, liberated Greek medicine from the mysticism of the priests and from the sophistries of the philosophers.

The followers of Aesculapius pretended to be his descendants, just as modern imitators and quacks advertise that they belong to the inventor and know the secrets of a preparation. Lydia Pinkham—long dead—still gives personal attention to any questions asked by suffering humanity.

Hippocrates is the "Father of Medicine" (460 B. C.), and he delivered it from the thralldom of superstition. His writings remain alone amongst the ruins of ancient medical literature. His knowledge was far in advance of his age, and he vigorously opposed the popular belief that epilepsy was demoniacal possession.

The Romans were more apt in learning their superstitions than they were in learning the arts of healing. Before the Greeks

instructed them, sickness was fought with charms and prayers to the gods and goddesses of disease.

Pliny said that "people believed in anyone who gave himself out for a doctor, even if the falsehood entailed the greatest danger." How unfortunately true this is of the present day quacks!

One of the earliest quacks was Endemus, who lived 15 B. C., and of whom Tacitus writes: "He made a great parade of many secret remedies with a view to extol his own abilities as a doctor."

The wearing of charms, amulets, beads and precious stones comes from the ancient world, and the practice prevails, especially among savages, but, how many people to-day wear charms, pendants, girdles, and other articles, not only as ornaments, but for supposed protection against disease, accident and evil. Their use arose from the primitive belief that diseases have a supernatural origin.

The ignorant invariably confound medicine with magic, but savage, philosopher, Egyptian, Malay, Jew, Catholic and Protestant, all are superstitious.

The hoof of the elk is used by Indians and Norwegians to cure epilepsy.

The heart of a lark fastened to the left thigh is a sure cure for colic.

An Englishman traveling in Africa found a letter that had never reached its destination because a native wore it as a charm against sickness.

Beetles are found, buried with mummies, placed there to guard them from evil.

Necklaces made from beads of peony roots were worn by Greek children to assist them in teething.

Pliny states that "If a patient drink the water in which he has washed his feet, it will cure the colic." "A tick from the left ear of a black dog, worn as a charm, will allay all pains." "Any plant gathered from the bank of a river before sunrise—provided that no person sees the gatherer—is a sure remedy against tertian ague." "Carry the

hairs from a goat's chin for quartan ague." "A fox caught alive, his tongue cut out, allowed to dry, and hung in a red bag around the neck, will remove cataract from the eye."

You smile, and think how absurd, but here are remedies I have met with during my practice in this enlightened twentieth century:

A young chicken, picked and cut open alive, placed quickly on a child's bare chest to cure pneumonia. Amber beads for croup. For rheumatism, a brass ring on the finger, a potato in the pocket, a girdle of tar rope around the waist, or a sea-bean in the pocket. A mixture of tobacco juice and vinegar for uncontrollable vomiting. Salt and kerosene oil for colds. A gold earring worn in the ear for earache. Pull the hairs up in the center of the scalp when the palate (uvula) drops down. To remove warts, tie the same number of knots in a string to correspond with the warts, bury the string on the way to church; when the warty person steps over the place where the string is buried, the warts will vanish.

Marcellus states that knots tied in a flaxen string, as many as there are letters in the person's name, tied around the neck and the letters pronounced as you go, will cause all eye pain to disappear.

Spittle was anciently a charm against poisonous snakes. One writer says: "Before getting out of bed in the morning, spit on your hands, rub all sinews, and say flee, gout, flee!"

Only a few weeks ago a very intelligent patient of mine told me that a tramp, whom he had befriended by giving him the price of a lunch, took away his warts by anointing them carefully with saliva. If this tramp comes to Jacksonville I hope Dr. Hanson will examine his saliva for negri bodies.

The Teutons deemed medicine a profession unworthy of men, and the Anglo-Saxons, before conversion to Christianity, had little medical history. It consisted

mainly of nostrums administered with religious rites by superstitious old women. Theodore, Archbishop of Canterbury, taught that it is very dangerous to let blood on the fourth day of the moon.

The Welsh had no gods of medicine or demons of disease, but charms and absurd concoctions characterized their early treatment of disease.

Medical science came to the Arabians through the Persians, the Greeks of Asia Minor. In A. D. 76 Baghdad became the most splendid city in the east. Over eight hundred physicians were licensed to practice.

Mahomet was skilled in the knowledge of medicine, but he believed he was afflicted with rheumatism by the witchcraft of wicked persons. The list of the great Arabian physicians is long, but mystery, astrology and charms were combined with the practice of medicine.

The East dates its civilization farther back than the West, but medical progress, like its civilization, now lags far behind.

The Crusades brought epidemic and contagious diseases from the East to Europe, where medical and surgical skill was confined to the monks, who consulted astrological oracles in curing disease.

The discovery of America marks an era when medicine, with the other sciences, awoke from long slumber.

Paracelsus (1493-1541) laid the foundation of modern medicine. Although he studied under a teacher of magic alchemy and astrology, he would not accept, as a blind guide, the teaching of his predecessors, but forsook all to follow truth. He replaced the filthy concoctions of his time with tinctures and essences.

In 1511 the English parliament passed the first act regulating the practice of medicine—to prevent ignorant persons from doing damage with witchcraft and sorcery.

In 1518 the Royal College of Physicians of London was established by Henry VIII,

for the repression of irregular and unlearned medical practitioners.

Materia medica up to the beginning of the eighteenth century was irrational and empiricism and superstition dominated medicine. Some prescriptions contained fifty-two ingredients. Loathsome and filthy medicines were frequently prescribed, and it is a peculiar fact that even today, among the ignorant classes, unless a medicine is nasty, dark in color and rich in sediment, it is considered impotent.

Sweat, human flesh, bats, blood, ear wax, and filthy excretions were common remedies. Even insects, tobacco juice, snake and lark tongues, oil of spiders, mould from church yards, and grated human skulls were used to cure disease.

Belief in magic is as old as the human species, and witches and impostors have always been competitors of physicians. Fortune tellers, dream interpreters, and spiritualists are still among us. They may be traced back to savages, but it will take centuries to get rid of them, because even cultivated minds, unless scientific, are superstitious.

The ancient Romans used red coral necklaces to ward off the evil eye, and red coral charms are still used in Italy to protect the wearer from the malocchio.

A knife that has killed a man is worn as a charm against disease in China.

A person with warts may have them removed if the same number of pebbles as warts are placed in a bag and lost; whoever finds the bag gets the warts.

Hair of the rabid dog is the only specific for hydrophobia. How much cheaper and simpler than the modern Pasteur treatment!

The dawn of modern science following the French revolution checked the general belief in disease demons, and with the general awakening of humanity to improvement, national health was considered. Blood-letters and medicine mongers were discounted. The homeopath helped by giv-

ing a billionth of a grain instead of a bolus.

But we still have foolish systems of medicine. As Tennyson said:

"Our little systems have their day;
They have their day and cease to be."

Berzelius said of Hahnemann, the founder of homeopathy, "That man would have been a great chemist, had he not been a great quack." And Hahnemann said, "All chronic maladies proceed from the itch," and decoctions of lice were recommended; for *similia similibus curantur*," or like cures like.

But as some one has well said: "Neither homeopathy nor allopathy were ever heard of, till Hahnemann chose to invent the terms, and, taking one himself, gave the other to all the rest of the medical world."

Why so many systems of medicine?

As Doctor Holmes remarked: "Medicine, sometimes impertinently, often ignorantly, often carelessly, called allopathy, appropriates everything from every source that can be of the slightest use to anybody who is ailing in any way, or likely to be ailing from any cause. It learned from a monk how to use antimony, from a Jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmaster how to sound the Eustachean tube, from a dairy maid how to prevent smallpox, and from an old market woman how to catch the itch insect. It borrowed acupuncture from the Japanese, and was taught the use of lobelia by the American savage. It stands ready today to accept anything from any theorist, from any empiric, who can make out a good case for his discovery, or his remedy.

Why do we have osteopathy, homeopathy, chiropractic, eclecticism, Christian Science, and a hundred other names of methods? If the truth is sought, they will use any and everything to relieve suffering, no matter what the school. While everywhere there is manifested a respect for the truth, yet accompany any busy general practitioner of

medicine on his daily rounds, visiting the sick, and your eyes and ears will see and hear the inconceivable, so great is the ignorance, superstition and susceptibility of people.

To us the most precious thing in nature is human life, and the conservation of health is the most important idea of our time.

The individual who pretends to alleviate suffering and conserve health, should have a comprehensive knowledge of the human body, and be familiar with the best means and methods of restoring health, when it is impaired.

An average man's life is estimated to be worth \$5,000, although the cost of killing a man in modern warfare averages \$15,000—in the Boer war the average was \$40,000 per man. On the other hand, Colonel Gorgas, whom I had the pleasure of meeting in Panama, converted the deadly Isthmus into a health resort at a cost of \$2.43 for each life saved; and the children of our Southland are cured of hookworm at an average cost of seventy-seven cents for each sufferer.

Life insurance companies, though selfishly active, are substantially assisting all health improvement agencies.

Since human life is so precious, and we are so boastful of the progress of our twentieth century, is it not remarkable that quacks and robbers are so plentiful?

The percentage of impostors in the regular profession is not great, but we have them. Any protest from physicians individually, arouses sympathy for the culprit, and his pocketbook grows fat from advertisements of martyrdom.

The words of John Salisbury, one of the most learned men of the twelfth century, applies today just as well to the advertising specialists, or rather quacks, as they did then. He said:

"They are full of flimsy theories to practice what they have learned. Galen and Hippocrates are continually in their mouths.

They speak aphorisms on every subject, and make their hearers stare at their long, unknown and high-sounding words. The good people think they can do anything because they pretend to all things. They have only two maxims which they never violate: 'Never mind the poor; never refuse money from the rich.'"

Only a few weeks ago a man and his wife, after ingratiating themselves with one of the negro congregations, introduced an aluminum cup warranted to cure any and all ills and aches by simply immersing the cup in water, and then drinking the water. Cups were purchased by a large percentage of the people, and the percentage of profit to the vendors was correspondingly large.

The Journal of the American Medical Association is now fighting such frauds, and almost weekly you may find articles exposing these glaring evils, in their propaganda for reform.* In last month's issue you will find the Pearl La Sage complexion treatment. Pearl says:

"No matter how atrocious your complexion in ten days you will have a pink, cream or downy one—just as you wish—and be the subject of wild admiration. Think of the mad tragedies of wives sitting alone at home, watching the clock through tear-dimmed eyes, when they fear some woman of a softer skin has coaxed their husbands from the paths of righteousness. The price I ask for my ten-day complexion treatment is \$10, but as Pearl wants your good will she offers it at the ridiculously low price of \$3."

Wait a few weeks and a letter will come offering the treatment for \$2.00; further hesitation brings the offer down to \$1.00, and her beauty book thrown in for good measure.

The Pearl La Sage treatment consists essentially of a weak solution of ordinary

soda and borax, colored with phenolphthalein, and sold at an exorbitant price.

When the public can be defrauded as easily as this, is it any wonder that actresses and others forsake the ill-paid drudgery of hard work for the "easy money" in fraudulent mail order schemes?

Another fraudulent scheme shown up by *The Journal of the A. M. A.*, was the widely heralded consumption cure of Peter P. Duket, M. D. Duket was a man of no scientific standing, unsavory professional reputation, and his cure gave eighty per cent mortality. As in all such cases, the public considered the criticism an attack on Duket personally, and ex-Senator Lorimer spent thousands of dollars to prove a self-evident fraud was a fraud. If this waste of money were all—but no—the most expensive part was paid for with the blasted hopes of a myriad of unhappy consumptives. It is in truth:

"Round the Calendar With the Dope.

"The patent medicine quack and his lies are nothing new. He has been spreading the same snares ever since human nature existed. Even the device of using the seasons to tempt you to purchase nostrums is not fresh. 'Max Adler,' an almost forgotten humorist of forty years ago, tells of an advertisement he read one winter:

" 'The excessive moisture and the extreme cold and continuous dampness of winter are peculiarly deleterious to the human system, and colds, consumption, and death are very apt to ensue unless the body be braced by some stimulating tonic such as Blank's Bitters, which give tone to the stomach, purify the blood, promote digestion, and increase the appetite. The Bitters are purely medicinal and contain no intoxicating element.'

"Spring came, bringing all her blessings, and he read:

" 'The sudden changes of temperature which are characteristic of the spring, and the enervating influence of the increased heat, make the season one of peculiar

* These articles are published monthly in *THE JOURNAL*, under the caption, "Propaganda for Reform," being furnished us by the A. M. A.—ED.

danger to the human system, so that ague, fever, and diseases resulting from impurities clogging the circulation of the blood can only be avoided by giving tone to the stomach and increasing the powers of that organ by a liberal use of Blank's Bitters.'

"When summer came, he hoped for a respite. On the contrary:

"The violent heat of summer debilitates and weakens the human system so completely that, more easily than at any other time, it becomes a prey to the insidious diseases which prevail during what may be called the sickly season. The sacrifice of human life during this dangerous period would be absolutely frightful had not nature and art offered a sure preventive in Blank's Bitters, which give tone to the stomach, etc., etc.'

"Nature and art as sponsors for patent medicine, is good. But autumn came at last with its life-giving breezes. Now he was confronted with this wisdom:

"The miasmatic vapors with which the atmosphere is filled during the fall of the year break down the human system and destroy life with a frightful celerity which is characteristic of no other season, unless the stomach is strengthened by constant use of Blank's Bitters, which are a sure preventive of disease, etc., etc.'"

Thanks to "Max Adeler" for his cycle of dosing! There has been no wiser or brisker comment on the way poor old nature is made a stalking-horse for dope.

But the dope will be manufactured just so long as it can be marketed.

The countless array of patent medicines, which line the shelves of drug houses is a disgrace to civilization; and the physicians owning drug stores which advertise quack remedies should bow their heads in shame, and be discountenanced by the public.

It is a fact—and I know it—that proprietors very often allow advertisements of such remedies, which are gotten up by the quack concerns, manufacturing the dope, when the nature of the advertisement and

the nature of the dope are unknown to the proprietor. Yet the medicine is unqualifiedly guaranteed by the druggist, who displays no interest except in the demand and profit thereon.

As *The Journal of the A. M. A.* says, such medicines usually derange the stomach, and the ability to digest food is a necessity, if the patient would successfully combat his disease. Hence, they invariably shorten life, and the only beneficiaries are the venders and the newspapers sharing the blood money.

Of all tainted dollars few are quite so dirty as those wrung by deceit and fraud from the unfortunate but ever-hopeful consumptive.

Journals, magazines and some newspapers are doing a great deal for reform by exposing such frauds, and all that is needed is public support of those clean periodicals, for such falsehood and filth now published concerning cure-alls to soon cease.

Collier's Weekly has done much in this direction, and a recent article on cancer is worthy of note:

"Cancer is the most justly dreaded of diseases. Strangely enough, in spite of its alarming increase and the universal terror which it inspires, less purposeful consideration has hitherto been given to it than to any other important problem of public health. The general ignorance of the subject is appalling when one considers that out of every ten middle-aged Americans one dies by its slow and agonizing doom; doubly appalling in the light of the known fact that a large proportion of the victims could be saved, either by preventive or curative measures, if they but knew how. The American Society for the Control of Cancer has recently been organized by a number of public-spirited men and women, with the main purpose of popular education on the vital topic. The public is to be taught three fundamental truths: First, that cancer is in the majority of cases curable, if taken in the early stages; second, that, quacks and

mistaken enthusiasts to the contrary notwithstanding, the knife is the only known cure; and, as a corollary to these two propositions, third, that prompt diagnosis and immediate recourse to a killed surgeon on the first suspicion of cancer means a highly probable saving of life, whereas neglect means inevitable death. 'Ah,' says Cynicus, 'another scheme of the surgeons to extract fat fees.' *The Baltimore News* in a convincing editorial refutes this oft-repeated superstition:

"As for the allegations, sure to be made by the rogues and vagabonds of medicine, that the surgeon undertake this campaign for their own profit, it is scarcely worth serious answer. If you have cancer, you may be sure they will get you, soon or late. After you have been tortured by caustics a dreadful space, you will land upon the operating table at last, and the fee you pay will not be the less because the labor you demand is the more. No; the surgeons will not be in pocket by this campaign. All they will get out of it will be the satisfaction of doing better work and of saving more human lives.'"

Ladies and gentlemen, you would appreciate this article so much the more had you been in Key West recently and witnessed the trial and conviction of a self-styled cancer specialist—or rather his second trial and conviction for practicing medicine illegally. Not one particle of evidence was ever produced to show that he was qualified to treat disease, yet he came out with a bold advertisement in a local paper claiming to cure any cancer with his serum. The members of the Monroe County Medical Society treated his pretensions as a joke until cases of evident malpractice, blackmail and criminal neglect came to our offices with pitiable stories of abuse by this impostor. In one week I had three persons in my office. One man had a cancer of the finger—having been treated by this specialist for seven weeks, and from the size of a bean the growth had increased so as to

involve the whole finger—necessitating an amputation to save the hand.

A young woman had two fatty tumors—one on the shoulder, the other on the knee. This specialist was consulted, and, after months of treatment, this woman came to me with large ulcerated areas over the tumors. She was losing flesh rapidly and the tumors were growing larger, so that she was in a state of physical collapse. Her story of agony and blackmail suffered was told the jury, and with the evidence of a score of others, the jury was obliged to return a verdict of guilty. Following the verdict, the morning paper had the following to say:

"A jury's decision yesterday morning destroyed the hopes of the afflicted of Key West, temporarily, at any rate, from being cured of one of the worst scourges afflicting the human race—cancer. By a hard-and-fast legal decision the law, which once was called synonymous with justice, stepped in and placed its gauntleted fist around the throat of the doctor, famous as the inventor of a cure for cancer." Mark you. "A genuinely heart-felt sob choked the throats of Key West people when the news became known. Those whom he had cured at first could scarcely believe that this man, who has given his marvelous skill and his wonderful invention freely to humanity for the past fifteen years—the last two here in Key West—had been stopped in the great humane work he was accomplishing. It seemed impossible that a Key West jury, recruited from a city where so much living evidence of his cures is to be found on the streets every day, had found the cancer wizard guilty, thus debarring him from practicing the remedy." Two-page ad., charged \$40.00.

Indeed! Did he give his marvelous skill and his wonderful invention freely to humanity? Not at all. Witnesses testified that he demanded and that they each paid him from \$25.00 to nearly \$200. He came to Key West as a painter, having previously

worked on the Florida East Coast Railway. He had no visible means of support except from his malpractice, and his serum was obviously a fake, for had it been at all potent, the application of caustic preparations used by him and which caused such agony, would have been unnecessary and, therefore, more humane.

Yet public feeling was so aroused because some believed him a martyr, others a Messiah, that he was not imprisoned at all after the last conviction. Two of his supposed cures have recently passed the great beyond, and a third sufferer on whom he had worked for months, is spending her few remaining days in agony, waiting to follow the other two. The relatives of this last victim were zealously active in having the "specialist" released because she had faith that she would be cured. Alas! One night, while suffering the tortures of the damned, she sent for this wonderful healer, and they found an empty house—where he had always lived. Vanished!

A few days ago a friend of mine from Cuba stated that he met this "specialist" in the Ohio Hotel in Havana, and he was still bragging about the wonderful cures effected in Key West. He was booked for the Isle of Pines, not so far away that the curses of those whom he has robbed of money and life may not haunt him. "A potent quack, long versed in human ills who first insults the victim whom he kills."

But friends, the truth must prevail. We are awakening, and the relation of physician to patient, and patient to physician, is changing for the better. Medical ethics of today are very different from those of 1803, when Doctor Thomas Percival, an English physician, compiled certain rules as a guide to his son in the practice of medicine. These rules were the basis for the code of medical ethics adopted by the American Medical Association on its organization in 1847. Strange to say that this code was not abandoned until 1903, when a compendium of principles was adopted in its place.

The medical profession was formerly regarded somewhat like the clergy—apart and somewhat superior to law and convention. Frock coats and evening clothes were regarded as essential to the dignity of a surgical operation, but we prefer the sanitary gown. The gown may not inspire awe, but it protects from germs. The clean shaven physician has replaced the one with the flowing beard, usually worn to impress the public with the doctor's skill.

The truth is, the guiding star in modern medicine—misrepresentation—must go. The physician that is true to himself and his patient's welfare, diagnoses and tells the sufferer from tuberculosis the nature of his disease, and the proper course to pursue in order that the trouble may be arrested. Lying for the patient's own good was considered justifiable in the past. Now the ordinary person knows that a persistent cough and loss of weight are danger signals, and the statement that it is merely "bronchitis," not only does not satisfy, but the lie will be found out.

A person with heart disease may live a great many years of useful service, if warned against unnecessary exertion and violence. Careful description of the trouble without alarm is the proper way, and it will be appreciated by the patient, who is grateful for such frankness; his confidence has been won legitimately. The same frankness should be common among consultants. For we all know that consultations among physicians have long been a matter of contempt in the public mind, and to a certain extent this contempt has been justified. It has been the experience, I know, of many physicians at this convention to have been called in consultation with a confrère and placed in a very undesirable position because of a disagreement with the attending physician. The modern code of ethics, however, says that the patient is of the first importance, and a frank opinion is what the patient is paying for. A physician who exults in the errors of his associates should

be condemned; but if the question is at all compromising to the patient's welfare the latter's interests are always paramount.

Ladies and gentlemen, I have attempted to trace from the earliest times of which we have record, the origin and growth of quackery, in the practice of medicine. That it exists today I believe I have proven, and that it leads to the grossest evils is very evident. These evils are due, first, to the superstitions of people; second, to the ignorance of patients, nurses and practitioners; third, to the secrecy of medicines and methods used by physicians, quacks, druggists, and fraudulent manufacturers; fourth, to the commercialism of those that exploit the public purely for mercenary purposes.

The remedies, I think, are just as evident. First, we must educate the people, practitioners, druggists and manufacturers, who have, from habit, done these things for so long a time that it scarcely seems wrong to them to continue; second, we must have publicity, which is always the best antidote for fraud; third, we must cultivate a moral sense in an all too material people, who have become imbued with the idea that the exploitation of the public is a natural law of business, and private gain is the only goal, for which they should strive; fourth, we need legislation, and our people of Florida have a splendid opportunity to make a beginning, for the true physicians of this State will make an effort to have passed in the next legislature a medical practice act, requiring of those who seek admission to the ranks of medicine a proper knowledge of subjects that are established and essential in the treatment of human beings. Florida is the only State in the south without a recent medical practice act, and I am sure you do not want our beloved State to be a dumping ground for undesirable quacks. See to it that your senators and representatives support the measure, by interesting yourself personally in the matter, and write or tell them you desire the measure passed.

At the present time the law is a distinct discrimination against true physicians, because it allows grossly incompetent and ignorant persons to treat disease. All of the different schools of medicine will be represented by a single board of examiners from the four schools of medicine recognized by the State, and the new law will not effect those men already holding license.

To enact this law, you will have taken a substantial step toward the eradication of quackery, superstition and robbery in the treatment of disease.

CYSTITIS—A SYMPTOM. REPORT OF CASES.*

J. C. VINSON, M. D.,
Tampa, Fla.

Cystitis has been for a very long time the most popular diagnosis of urinary disorders. No doubt the cause of this peculiar fact has been our inability, through lack of instruments of precision, to understand the different diseased conditions of the genito-urinary tract. In its final analysis this really means ignorance. Another potent factor has been the persistence in which all text books have described cystitis as being a disease *per se*. The vast majority of those cases that present symptoms referable to the bladder have their cause in some other part of the genito-urinary tract, and if the bladder condition is viewed in any way other than as a symptom, the treatment will not be a logical one.

The cystoscope, ureteral catheter, and X-ray have made it possible to reach a scientific conclusion, and it has been possible by these means to prove the absurdity of making a diagnosis of cystitis, and treating as such those cases that present the classical symptoms of vesical irritability. The improvement in instruments, and the modern additions to be used in conjunction with the

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

cystoscope and X-ray have given to us an almost perfect method of reaching conclusions as to the location of diseased conditions of the bladder and kidneys. Cystoscopy and roentgenography do not replace the older methods of diagnosis, but may be used in conjunction with them. I do not intend to convey the idea that the diagnosis of bladder and kidney lesions can be made with rapidity, or without a considerable amount of study. The patient must be impressed with the importance of the time required to carry out the proper procedure so necessary for a final scientific conclusion.

Case No. 1. F. B. T. Female, age thirty-eight, consulted me for periodic attacks of cystitis. Mother died at the age of forty-eight with cancer of the rectum. Has been married twenty years. Was well until nineteen years ago, at which time she gave birth to a normal child. Three days after she had retention of urine, which the doctor relieved by the use of a catheter. She states that immediately after she began having cystitis, and suffered considerable pain when passing urine. Her symptoms continued until her second child was born, three years later. Following the birth of her second child she was fairly comfortable for three or four weeks, but at the expiration of that time the trouble returned, and continued until three years later. She consulted a physician at Gainesville, Ga., who drained the bladder through the vagina, and removed a piece of catheter two or three inches long incrustated with a heavy deposit. The drainage was continued for a few weeks, and healed without any more trouble. She remained well for about a year, when, after a long walk, there was a return of the cystitis lasting for three or four weeks. Since then she has had similar attacks about two or three times a year. Four months ago, after a long walk, she had a return of the trouble which has persisted since, confining her to her bed, and resulting in a loss of from ten to fifteen pounds. She is now

passing urine every fifteen or twenty minutes with considerable pain.

Physical examination, negative. Urine showed the presence of a considerable amount of pus, otherwise negative. Cystoscopic examination. Simple Trigonitis. Just behind the interureteric bar the base of the bladder dips down funnel shaped towards the vagina, simulating a diverticulum. Ureteral catheterization. Right and left kidney, negative. An examination of the vagina showed a pin point opening at the point of the drainage wound.

Diagnosis: Vesico-vaginal fistula.

Case No. 2. Mrs. W., married, age forty-eight. Seen first in June, 1909, complaining of frequent and painful urination, and at times passing a slight quantity of blood. Family history, negative. Past history: For the last ten years she has suffered from intestinal putrefaction, has been very constipated, but for the last six months has noticed improvement in her intestinal trouble. Seven years ago she began to notice an uncomfortable feeling in her bladder which has gradually grown worse, and for the past two years she has had a constant desire to urinate. She noticed blood in her urine for the first time about six months ago, and since then it has recurred, always after a long walk. For the last four months she has been compelled to pass her urine twelve to fifteen times a day, and once or twice at night, micturition always being accompanied by pain. For the past month her bladder has been irrigated daily with a saturated solution of boric acid. She noticed marked relief while being under treatment, but the symptoms return when she misses two or three irrigations. Physical examination, negative. Urine examination, negative. Urine examination, large amount of pus, and a few blood cells. Cystoscopic examination. A stone the size of a walnut was found.

Case No. 3. J. F. Mc. Female, married, age twenty-six years. Presented herself complaining of painful urination, and the

constant passage of blood in the urine. Family history. Father died at the age of fifty years from inflammation of the bowels, and was practically an invalid for three or four years before death—otherwise, negative.

Past history: Typhoid fever ten or twelve years ago. Has had three children, youngest nine months old. Was apparently well until about three years ago, at which time she had a painless hematuria which continued for about one year, at times almost disappearing. Did not consult a physician at that time. Two years ago she first noticed pain and frequency, and began passing a considerable amount of thick, greyish matter. These symptoms gradually increased in severity, and eighteen months ago she consulted a physician and was treated by bladder irrigation and urotropin internally, with marked relief from pain and frequency, but has noticed no decrease in the amount of blood passed. Nine months ago she had a normal delivery with a healthy child. For one or two months after birth of the child she felt very well, but for the past two or three months has been having considerable pain on passing urine, and a constant desire to urinate, together with an increase in the amount of pus and blood. Cystoscopic examination. Large cauliflower-like growth, pedunculated, situated on the left side of the trigons and extending very close to the left ureteric orifice. A single pedunculated tumor situated in the base of the bladder in the medium line. Examination unusually difficult on account of the bleeding. Diagnosis: Villous papilloma.

Case No. 4. G. L. L. Male, age forty-two, lawyer. Presented himself for consultation complaining of difficulty in passing urine, with a considerable amount of post-micturition pain. Past history: Gonorrhea, first in 1889, duration six months. With this case he had double epididymitis. Second case of gonorrhea in 1893, duration four months. Last attack three years ago, since that time has not seen any discharge. In 1898

had a sore on penis which lasted for five or six weeks. Under treatment of a physician he began to take mercury pills, but the sore did not heal until the mercury treatment was suspended. Has had no evidence of syphilis since, but has continued to take mercury and potassium iodide two or three months in each year. For the past two years he had had periodical attacks of rheumatism, confined mostly to his legs. In 1898 was treated with sounds. Three years ago he noticed slight trouble in beginning to pass urine, which has gradually increased, and for the last six months he has experienced extreme difficulty in passing urine. He states that it requires his absolute attention to urinate and that when his mind is diverted urine fails to flow. Physical examination. Left testicle atrophied. Prostate very small and soft. Urethra carries No. 30 bougie a boule. There is four ounces of residual urine. Examination of urine, negative. Cystoscopic examination. Trabeculated bladder, with diverticula. Diagnosis: *Tabes* confirmed by A. R. pupil, Rombergs and loss of patella reflexes, and positive Wasserman.

Case No. 5. W. C. C. Male, age twenty-four. Consulted me in November, 1912, complaining of pain in the glans penis, frequency, and post micturition discomfort. Family history negative. Was well until four months ago, at which time he noticed a slight discomfort on passing urine, and a few weeks later he was compelled to pass his urine often. These symptoms have increased in severity, however, and at times he is worse than at others; for the past week has been passing his urine every few minutes, and has severe pain at the glans penis. Physical examination. Showed tenderness at right costo-vetebral angle and along the right ureter. Examination of urine showed slight albumen, considerable pus, and after repeated examinations, tubercle bacilli. Cystoscopic examination. Trigone considerably inflamed, quite a few tubercles around the right ureteric orifice.

Ureters catheterized. Left kidney, urine clear, P. S. P. test 30 min., 9 min. 20 per cent. Right kidney, urine opaque, pus. P. S. P. test 30 min., 20 min. negative. Diagnosis: Renal tuberculosis of right kidney.

The histories given above represent typical every-day occurrences, and in each case there has been made a diagnosis of cystitis. Each patient felt convinced that the extent of the trouble was represented by the "inflammation of the bladder," and even continued treatment, though futile, had not shaken their belief in the first diagnosis. They did not expect to undergo a systematic examination, but were under the impression that they might find some doctor who would, by the use of some mysterious lotion, cure them of their "cystitis."

Conclusions: First, the necessity of systematic examination is plainly demonstrated.

Second: The recognition of bladder irritability as a symptom, not a disease.

Third: The futility of diagnosing a case as cystitis.

THE ABUSE OF THE CURET.

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It is my firm conviction that at least seventy-five per cent of the countless thousands of curetments which have been and are being done for therapeutic purposes are unnecessary; and that fully half of that number are productive of harm, if not of actual disaster. Why this condition of affairs continues to prevail despite the warnings of able teachers the world over, I am unable to say, unless it is one of those empirical procedures which continues to be done as a matter of course, without any logical con-

sideration of its indications or consequences.

I realize, gentlemen, that the curet has been the subject of innumerable papers and discussions; but I realize also, if you please, that until it has suffered a decided falling from grace as a therapeutic asset, the subject can not be considered threadbare.

As Dr. J. B. Murphy said, "Some physicians carry their curet and toothbrush in the same pocket, and use one about as often as the other." There seems to be a general feeling of confidence in the safety of the procedure and the results to follow, which does not exist concerning any other surgical procedure. There are men all over the country who would not think of doing any major surgery upon any other part of the body under similar conditions; yet they will put a patient across the bed with her feet on two chairs, possibly shave the vulva, possibly not, and blindly plunge their sharp curet into an already disabled uterus; ruthlessly destroy nature's efforts to protect her charge against the ravages of the invading infection; and, when eight to twelve hours afterward the patient has a chill, fever and pelvic pain, wonder what dire things might have happened had they not curetted.

Given a patient with any variety of pelvic symptoms whatever, and the second thing which enters the doctor's mind is a curetment; the first is a douche. The patient's mind runs in the same channel. I think every patient whom I have ever seen with pelvic symptoms has either had a curetment, been advised to have one, or wants one herself. I feel that a large number of the curetments which are being done are the direct result of the failure on the part of the attending physician either to properly analyze the cause of the symptoms preoperative, or to properly analyze the morbidity post-operative. It would cease to be his sheet-anchor in gynecologic treatment, if he once stopped to realize how seldom it is productive of a cure, and how often it is productive of harm.

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

As a general rule the cases which are being subjected to curetment (except those for diagnostic purposes, which are not considered in this paper) may be grouped under two general classes.

(1.) Those long standing cases of pelvic disorder which drift from doctor to doctor, and from patent medicine to patent medicine, getting oceans of treatment with here and there a drop of diagnosis.

(2.) Those acute cases of pelvic infection and retained membranes following miscarriage and parturition.

We all realize that the one great principle in therapeutics is to remove the cause of the symptoms. Let us see how often curetment does this. The most prominent symptoms in the first class of cases are:

(1.) *Leucorrhœa*. Far and away the majority of leucorrhœal discharges originate in the lower genitalia from the vagina and cervix, cervical lacerations, erosions and endocervicitis. Curtis¹ in a recent study of the bacteriology of leucorrhœal discharges in seventy-five cases was unable to demonstrate a single case where the discharge originated in the uterine cavity, and cultures taken from above the internal os were invariably sterile. Why curet these cases, and by so doing deliberately plant the seeds of infection higher up in the uterine cavity, after having scraped away the endometrium, leaving a nice broad raw area for their reception? Are we removing the cause?

(2.) *Pain*. Pain in the majority of instances can be traced to retrodisplacements, obstruction to menstrual discharge, or adnexal infection. Possibly the endometrium is secondarily congested in all of these conditions, and is, due to the passive congestion, secreting a mucous discharge; but is that sufficient reason for scraping it off when the primary pathology is elsewhere? We do not curet the congested mucous membrane of the bladder after removing a stone.

(3.) *Menorrhagia and Metrorrhagia*. In these cases the curet is frequently of signal service in a diagnostic capacity; but of what possible therapeutic value is it in cases of cancer, fibrosis of the myometrium, myomata or disease of the adnexa, which together constitute the cause of the bleeding in the vast majority of these chronic cases?

The following case taken from my records is typical of some of the cases which are being subjected to useless curetment:

Case 1. Mrs. A., forty-two years old, married, no children and no miscarriages. Came to me September 28, 1912, complaining of irregular and profuse menstrual flow. Periods occurring at intervals of two to four weeks, and lasting one to three weeks, accompanied by bearing down pains, backache, a sense of dragging weight in the pelvis, with occasional severe lower abdominal cramps. There was a rather profuse leucorrhœal discharge between the periods, which was constant and required the wearing of napkins. The above symptoms all came on insidiously after the age of thirty and had become gradually worse. Four years ago the bleeding was worse for six weeks, at which time she consulted a physician, who did a curetment. The bleeding ceased for four weeks and then became just as severe as before. Leucorrhœa and subjective symptoms remained the same. Six months ago she was again curetted, following three weeks of profuse bleeding. This time she did not even experience temporary relief. The bleeding became intermenstrual, and has never been entirely absent since. Three weeks ago, following a sharp hemorrhage, she was advised to submit to a third curetment, which she very properly refused to do.

Upon examination I found a uterus enlarged to the size of a six weeks' pregnancy, hard, movable and in the retroposition, with normal adnexa. A hysterectomy was advised with a tentative diagnosis of submucous myoma.

¹Curtis, A. H., On the Etiology and Bacteriology of Leucorrhœa. Surg., Gynec. and Obst., 1914, XVIII, 299.

The specimen showed a diffuse fibrosis of the myometrium, three small marble-like submucous myomata, and several interstitial ones of similar size. There was no evidence of malignancy. The patient reports that she is well and strong at this time.

The most palpable of this woman's symptoms, and the one which was most endangering her life was the bleeding. What caused this bleeding?

Sampson,² who has been doing such admirable work on the effect of myomata on the blood supply of the uterus, gives as the chief causes of bleeding in these cases:

"(1.) Irregularity of the uterine cavity, allowing incomplete obliteration of the cavity when the uterus contracts.

"(2.) Loss of tone of the myometrium due to fibrous overgrowth.

"(3.) Hypertrophy of the chief venous plexuses, the endometrial and the myometrial."

By what possibility could a curetment remove any one of these causes of bleeding? Yet two were done and a third advised on this case.

It is in the second class of cases that most of the real post-operative disasters occur.

If there is active bleeding, post-abortive, with parts of the products of conception retained in the uterine cavity, either the vagina should be packed to cause dilatation of the cervix and extrusion of the membranes by nature; or the cervix should be gently dilated and the membranes removed with a pair of sponge forceps, with the least possible trauma to the uterine cavity. If the cervix is forcibly dilated, small tears are almost certain to occur, giving any existing infection access to the richest lymphatic area of the uterus, and inviting cellulitis of the parametrium.

The infected case, following a criminal or self-induced abortion, where the uterus is

large and boggy, and the discharge foul, should be the *noli me tangere* of the physician.

If you should suggest curetting the cavity of an appendix abscess to a physician, he would throw up his hands in holy horror, yet he will, with the slightest provocation, curet the cavity of an infected uterus. What is the difference? Is it not just as rational to scrape away nature's cofferdam of leucocytic infiltration in one part of the body as another? In curetting an infected uterus it is true that the gross, desquamated products of infection, which do not harm *per se*, and which nature is throwing off slowly, are gotten rid of at once; but at the same time nature's firing line of bodily protection is demolished and the infecting organisms are allowed to rush pell mell into the wide open mouths of the lymphatics and venous sinuses. Not only allowed to enter these sacred portals, but frequently literally forced into them by the use of an intra-uterine douche. All that I can say of a uterine douche under such circumstances is that it is adding insult to injury.

Stowe³ reported in 1912 fifty deaths from puerperal sepsis in Cook County Hospital, most of which had been curetted before entering. The records of those cases form a chain of catastrophes, which stands as a gruesome example of ill-advised interference. If the curetted patient recovers, it is in spite of the treatment which has turned the odds against her.

Recently I was called by a physician to see a case of his which was typical of this class of cases—a large, boggy, tender uterus, a foul odored vaginal discharge, temperature 102½ and part of the membranes retained. This physician had his patient in the Fowler position with an ice-cap on the lower abdomen, "giving ergot and *doing nothing locally*. That, gentlemen, is what I call masterly inactivity. His

²Sampson, J. A., The Influence of Myomata On the Blood Supply of the Uterus. Surg., Gynec. and Obst., 1913, XVI, 144.

³Stowe, H. M., A Study of and Deductions From Fifty Fatal Cases of Puerperal Fever. Surg., Gynec. and Obst., Jan., 1912, p. 20.

patient recovered with no resulting pelvic morbidity. He let a self-limited infection alone. He aided nature in the best possible way by favoring drainage by gravity and by supporting the general bodily functions. His mortality and morbidity are certain to be slight in these cases as long as he treats them with an air of watchful waiting.

When the victims of these ill-advised curetments do not succumb to the immediate effects of the treatment, a large number of them are destined to become gynecologic semi-invalids, and to be forced to undergo operative procedures for the relief of the morbid anatomy which is left in the pelvis as a direct result of improper management.

The following cases abstracted from my records are cited here as typical examples of this class:

Case 2. Mrs. B., thirty years of age, entered the gynecologic department at St. Luke's Hospital in September, 1912, with the history of having had a self-induced abortion six weeks previously. One week after abortion she called a physician on account of a foul vaginal discharge and pelvic pain and tenderness. The physician curetted her at home, and twelve hours later she was seized with a severe pain in the lower right quadrant of the abdomen, followed a few hours later by pain in the left side, at which time she had a chill and became delirious. Chills, irregular temperature, sweats, and bilateral lower abdominal pain continued until she entered the hospital four weeks later. When I saw her the day she entered, she had a temperature of 103, pulse 130 and was evidently septic.

Abdominal examination revealed a tender mass the size of a grapefruit in the lower left quadrant of the abdomen. The mass proved to be an abscess of the left broad ligament. Leucocyte count was 27,000. A vaginal section evacuated a pint of foul colon pus. The treatment following this will be omitted. Suffice it to say that sixty-six days later this patient was in condition

to have a laparotomy done for the removal of her pelvic ruins. She was discharged December 29th in good condition, but minus her uterus, both tubes and the left ovary.

Case 3. Miss C., twenty years old, entered gynecologic service of St. Luke's November 18, 1912, with the following history: Three months before, a criminal abortion by the use of a catheter; a week later a curettage at home by a physician; eighteen hours later a chill ushering in an attack of acute pelvic inflammation with pain, tenderness, chills, fever and sweats, lasting four weeks. Since that time she has had constant pelvic pain on both sides, worse when on feet, and a profuse leucorrhoeal discharge. Two weeks before entering hospital she had an acute attack of pelvic inflammation following a strain. Examination on admission showed: Temperature 102, pulse 100. Lower abdomen very tender to palpation. Bimanual examination showed that the uterus was retroverted and adherent in the cul-de-sac, and an inflammatory mass the size of a hen's egg to the left of the adherent fundus. She was put on expectant treatment and the temperature dropped to normal in two days, and had remained so for ten days, when the service changed and she was turned over to Dr. G. R. Holden, coming on service at that time.

Dr. Holden's records show that on December the 11th he did a laparotomy and removed both tubes and the left ovary. She was discharged in good condition on January 1, 1913.

Case 4. Miss D., age nineteen, entered the hospital October 13, 1912, with a history of having had a self-induced abortion seven weeks previously. Ten days later there was still slight vaginal bleeding, and a profuse foul odored discharge. She consulted a physician who advised a curetment. This was done at home. Twenty-four hours later she began to suffer severe pain in the left iliac fossa, fever and chilliness. Pain became general over the lower abdomen after a few hours, and necessitated her remaining

in bed for ten days. Since then there have been irregular attacks of pelvic pain and tenderness and occasional slight chills. There had been marked bladder irritability since the onset of the trouble.

Examination upon admission elicited the following findings: Temperature $100\frac{1}{2}$, pulse 88, leucocytes 10,000, general lower abdominal tenderness, worse on the left side, profuse yellowish vaginal discharge. A mass the size of an orange in the cul-de-sac, hard, tender, non-fluctuating, and seemingly involving all the pelvic viscera. She was put on expectant treatment, and six weeks later a laparotomy was done and the left tube and ovary and right tube removed. Discharged from the hospital December, 1912.

These histories are typical of a majority of the pelvic inflammatory cases comprising my records. They date the inception of their invalidism from the curetment. These cases are so similar, and the sequence of events so constant, that when I see a woman presenting a pelvis full of incarcerated ruins, I can almost write her history by asking her one question: "When was your womb curetted?"

A word about the pathology of these cases and the fallacy of trying to remove it with a curet.

If the infection is local in the uterine cavity, and is a result of the ordinary pyogenic organisms, it tends to remain local, to be self limited, and to be thrown off by nature, aided by postural drainage and supportive treatment, unless the efforts of nature be defeated by a meddlesome curetment.

If the infection is by the streptococcus it tends to rapidly become subserous, and to spread in the retroperitoneal tissue, out of reach of either a curetment or abdominal drainage.

If the ordinary pyogenic infection has ceased to be a local one and has spread into the cellular tissue of the parametrium, or into the pelvic veins, as is evidenced by

rise of temperature, chills, lower abdominal pain and rigidity, it is manifestly impossible to reach it with a curet, and only damage can result from its use.

In conclusion I will only mention a class of cases where the curetment is reflexly harmful—not from the injury to the endometrium but from trauma to the adnexa during the manipulations.

I have seen a number of cases where a woman has swapped a mild, subacute tubal infection, with its concomitant symptoms, for an attack of acute pelvic peritonitis, due to breaking up of adhesions, and liberation of infection. None of us will doubt that she made a poor swap.

It has been my fortunate experience not to have been called upon to treat the most glaring of all the casualties due to the curet, puncture of the uterus, so I will simply mention it in closing, as a rather too common possibility.

MEDICAL INSPECTION AND EDUCATION OF SCHOOL CHILDREN THE MOST PROBABLE SOLUTION OF HOOKWORM, MALARIA AND OTHER INFECTIOUS DISEASES.*

J. C. DAVIS, M. D.,

Quincy, Fla.

It is the intention of the writer to show what may be gained by examination of school children, and what is possible to accomplish by also educating them along sanitary and hygienic lines.

The recognition of backward and defective children in school is of grave importance. Frequently the backward child is supposed to be defective and at times is even thought to be imbecile, whereas if he were trained properly and his physical defects corrected, he would take a proper place with his fellows. Some of our most prom-

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

inent men have been dullards in youth. If, therefore, these children could be taken in hand and a special class organized for them they would frequently make useful citizens.

School inspection is one of the most important steps that can be taken for the conservation of the race, for there are certain types of insanity—such as dementia praecox, which, if taken in time, could be saved. Frequently it is necessary to take such children out of school entirely and train them manually. It is better to have one who could earn his support with his hands than to have a vegetating dement shut up within the walls of an insane asylum for life.

Every effort should be made toward the upbuilding of the race, defectives should be segregated: the backward helped and everything done which would tend to make the best citizens physically, mentally and morally.

We as Floridians have a right to feel proud of any developments that we might accomplish along the line of public health work and we will not be far behind other States of the nation in placing a proper value on the lives of our citizens by the expenditure of effort for the preservation of health and the prevention of disease. Organized society has accomplished much in some of the larger cities of the nation in the way of medical inspection of schools, the correction of physical defects of school children, the employment of school physicians and nurses, the operation of special schools for mental defectives, and the instruction of parents through school physicians. The scope of this work deserves State-wide attention as a unit, because to accomplish much by these endeavors close organization is necessary, for after all we are but one big family and if we do not practice the principles of hygiene and sanitation alike everywhere our time will be wasted and our efforts in a good cause fail.

"From a professional standpoint if we were asked to state the true and ultimate

object of school hygiene and sanitation we would invariably answer that it is to safeguard the health of the pupils and to improve their physical and mental conditions by removing those defects which interfere with the child obtaining a normal education with comfort."¹ Let us use this principle as a basis for our plan. Applying this plan to a consideration of school hygiene and sanitation, an outline of the topics for discussion would be a consideration of the personal hygiene of the student, the conditions of his health, his habits, the amount of work he can and should do, the sanitary environments and requirements of the schoolroom and building, the furniture, the ventilation and heating, and the influence of all these upon the individual's state and his development.

We know that the best time for the attainment of any knowledge is in the years of childhood, for it is then that the whole organism is growing and developing both mentally and physically and yields more readily at this period to both external and internal impressions and forces. If the growing period is the time for the attainment of mental culture it is the proper time for the practice of physical culture, for what has been gained when a highly developed mind is allowed to degenerate, owing to the physical welfare of the individual not having been preserved? "A sound mind is a sound body" is the keynote, which, coupled with a knowledge that will preserve health, for health is more easily retained than regained, will enable us to reach a higher state of civilization than has ever yet been attained, for we have the opportunity to make the children of today capable of accomplishing greater things in their years of service, than those of any previous generation.

As the years go by the realization of responsibilities by the people for the preservation of health and the prevention of

¹ Jordan, W. S.: Transactions of N. C. Med. Society, "School Hygiene and Sanitation," 1911, p. 93.

disease continually grows and more rapid strides will be made in the future than have been made in the past for the reason that the application of these principles is being forced by public sentiment, and since an enlightened public sentiment is becoming more general all the time, as a result of this campaign of health, we can surmise with optimism what the future holds in store.

In discussing such a subject as school hygiene and sanitation the great influence of all those circumstances and conditions common to school life can be readily understood. The importance of a knowledge of school hygiene is essential, for it concerns the parent, physician, teacher, pupil and citizen.

Overwork in children with lowered vitality may produce dyspepsia, headaches, nervous derangements, St. Vitus dance, epilepsy, backaches, disorders of menstruation, and tuberculosis. I believe that overwork could in a large measure be prevented if the teachers would grade more by the actual work done and attendance during the term, than depending on the results of final examinations. In this way, the same amount of work throughout the term would be seen not to exceed the capacity of the students instead of forcing the children to cram for examinations at the close of a term.

Appreciation of health, as well as its neglect, is indexed by the physical condition of school children. Physical examinations will discover what parents are trying to do as well as what they fail to do because of ignorance, indifference, or poverty. In so far as parents are alive to the importance of health, the examinations furnish occasion of enlisting them in crusades to protect the public health and to enforce health regulations. Generally speaking, fathers and mothers can easily be interested in any kind of campaign in the name of health on behalf of their children. "The advantage of starting a health crusade in the most popular American institution, the public school, and the advantages of instituting corrective work

through democratic machinery, such as exists in the public school, is incalculable. To any person wanting to take the necessary steps for the removal of conditions prejudicial to health and for the enforcement of health regulations for child and adult, the best possible advice is to learn the facts disclosed by physical examination of school children."² See that these facts are used first for the benefit of the children themselves, and secondly for the benefit of the community as a whole. Where school inspection has not been introduced, take steps at once to institute it and, if necessary, volunteer to examine a class, persuade your other brother physicians to examine others and thus make an honest effort to prove to parent, taxpayer, health official, and teacher that such an examination is both a money-saving, energy-saving step and an act of duty and justice.

Mere inspection and examination of school does no good. The child does not breathe better or see better because the school physician fills out a card stating that there is something wrong with his eyes, nose, or tonsils, neither does the inspection report of sanitary nuisances remove the dangers of those on the grounds. The inspection demonstrates where the sanitary nuisance exists, and the examination the presence of physical defects, some of which may furnish source of contagion. After a thorough examination, all defects having been observed, the parent is notified of the child's condition. It is then that the school physician should co-operate with the family physician and make effort to remedy existing defects. Should the parent not be financially able to have the child properly looked after, it then becomes necessary for the health officials to see that the child is properly cared for.

Such a physical examination is rightly due every child, no matter where his schooling or at whose expense, for every child has

² Knopf, "School Hygiene," U. S. Bureau of Education, 1913, No. 48.

the right to advance as fast as his own powers will permit without hindrance from his own or his playmates' removable defects. He has the right to learn that simplified breathing is more necessary than simplified spelling, that nose plus adenoids retards progress, that a decayed tooth multiplied by ten gives malnutrition, and that hypertrophied tonsils are even more menacing than hypertrophied playfulness. He has the right to learn that his own mother in his own home, with the aid of his own family physician, can remove his physical defects so that it will be unnecessary for outsiders to give him a palliative free lunch at school, thus neglecting the cause of his defects and those of his fellow-pupils.

Bass,³ in a most excellent article entitled "The Eradication of Malaria," writes: "All that is required for the complete eradication of malaria is for everybody who had malaria during a warm season to take the proper amount of quinine on each of two consecutive days in each of six consecutive weeks during the following cool season." We all know that malaria is transmitted from one individual to another only by the bite of certain species of the anopheles mosquito, that the anopheles mosquito is a wild mosquito and lives and breeds in swamps and thick growths of vegetation, feeding only between sunset and sunrise, that they will not fly any distance over land not marshy or covered with rank vegetation, and that they must first bite a malarial carrier before they are capable of transmitting the infection.

Accepting the statement just made it would be an easy matter to have the blood of all children examined for the malarial plasmodia and to have those found infected properly treated. Just here I wish to state that it would be an easy matter to teach the children in the grammar school with sufficient emphasis to make an everlasting impression; the etiology of malaria, its mode

of transmission, the life of the malarial plasmodia, the habits of the mosquito, and the conditions favorable for their proliferation. In this way you will get the crusade going. The parent will be interested in what the child has been taught at school, and possibly be reached in that way when all other means would fail. The important facts relating to the prevention of the disease could be stated on one, two, or three pages of some textbook, for instance, the third or fourth reader, or be taught by the principal or school physician. What has been said in regard to the education of the child in the prevention of malaria may be well applied to hookworm, tuberculosis, and other infectious diseases.

A goodly number of the seemingly delinquent, defective, and backward children are of syphilitic origin, and before classing them permanently with the defectives, a Wasserman test should be applied, and if positive, antisiphilitic treatment inaugurated.

Health lessons and simple instructions in the prevention of disease, such as tuberculosis for example, can easily be imparted to the youngest school child.

Lessons in mental alertness, in what to do in hours of danger, such as the event of fire in school or at home, or a panic from whatever cause, and instruction in first aid to the injured, are to my mind as essential as any health lessons.

In cases of epidemics of diphtheria preventive injections of antitoxin should be given to all children exposed. When parents object to this procedure, their children should be excluded from school until the epidemic has ceased.

In case of typhoid epidemics antityphoid vaccination should be resorted to.

Every large community should have a special outdoor or fresh air classroom for children afflicted with whooping cough.

Sanitary fountains furnishing good, cool water should form part of the equipment of every school, and the drinking of plenty of such water should be encouraged.

³ Bass, C. C., "The Eradication of Malaria," *Interstate Med. Jour.*, 1912, XX, p. 921.

Lessons in embryology and biology, leading to the explanation of sex relation and eugenics should be given according to the age and understanding of the pupils, and in the higher grades preferably by teachers of the same sex as the pupils.

To accomplish much along these lines we must be enthusiastic over the great work. It has been said "that enthusiasm is the motive force of progress." No really great deeds were ever done in arts or arms, in literature or science that was not the product of enthusiasm.

May we feel it! May we be animated by this immortal principal; may we be driven by the divine fire! And of our work, let us see to it that when the final summons comes it can be said of us, "Greater love hath no man than this that he lay down his life for his friends."

PROPAGANDA FOR REFORM.

WINE OF CARDUI.—The Chattanooga Medicine Company claims that no more alcohol is used in Wine of Cardui than is needed to preserve it and that it can not be used as a beverage. In view of this the terms "booze" and "tipple" can not be applied to the preparation. (*Jour. A. M. A.*, June 6, 1914, p. 1827.)

CYSTOGEN.—At a meeting of physicians recently, the question was asked: Why is Cystogen, which is just plain hexamethylen amin, not recognized by the Council on Pharmacy and Chemistry? The answer is simple: Because the therapeutically suggestive title as well as the method of exploitation encourage its indiscriminate and ill-advised use, both by the medical profession and the public. (*Jour. Mo. State Med. Assn.*, June, 1914, p. 473.)

BUFFALO LITHIA WATER.—The fallacy that diseases are due to uric acid and the fallacy that lithium would eliminate the uric acid has made mineral waters highly profitable—even when lithium was present only in infinitesimal amounts. One of the most widely used "lithia waters" was Buffalo

Lithia Water, later called Buffalo Lithia Springs Water, which has been declared misbranded by the federal courts because it was shown to contain less lithia than does Potomac river water and that a person would have to drink 150,000 to 225,000 gallons of water to obtain an ordinary dose of lithia. The testimonials certifying to the high efficiency of Buffalo Lithia Water and its superiority to lithium compounds given in the past by physicians eminent in their profession, certify to the unreliability of clinical observations. (*Jour. A. M. A.*, June 13, 1914, p. 1909.)

THE ABSORPTION OF IRON.—The belief that organic compounds of iron were superior to inorganic iron salts arose before it was known that the bowel forms the most important channel for the excretion of this element, whence the failure to find an increase in the amount of iron eliminated with the urine by means of the kidneys after ingestion of the element in some form or other was taken as an indication that it had not been absorbed. Today it is known that iron can be absorbed and excreted by the intestinal wall. Experiments have demonstrated that both inorganic and organic iron can be absorbed and satisfactorily carry out the purposes for which iron is administered. (*Jour. A. M. A.*, June 13, 1914, p. 1913.)

MONADNOCK LITHIA WATER.—While extravagant curative claims were made for this "lithia water" examination showed it to contain only traces of lithia and hence it was declared misbranded under the Food and Drugs Act. (*Jour. A. M. A.*, June 30, 1914, p. 1981.)

SUN-RAY SPARKLING WATER.—While represented to be "the world's purest water," it was water to which sodium chloride, sodium bicarbonate and carbon dioxid had been added. Accordingly the company which sold the water was found guilty of misbranding under the Food and Drugs Act. (*Jour. A. M. A.*, June 20, 1914, p. 1981.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, 334 St. James Building, Jacksonville, Fla., U. S. A.

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Next Meeting—DeLand—May 12-14, 1915

THE JOURNAL.

Following the appearance of our initial number THE JOURNAL received many letters of commendation on its general appearance—the character of reading matter and the quality, as well as quantity, of advertising matter. We do not, however, wish to remain at a standstill but to continually progress. Because we now publish a good journal is no reason why we should not publish a better one. Are you willing to help us do this? There are a number of factors that go to make an attractive medical journal. In the first place it must contain a certain amount of original scientific reading matter. Original contributions and reports of cases are therefore solicited. If every member of the profession will do his share in contributing to the scientific columns of THE JOURNAL, we can at an early date materially increase the size of our publication. It will, of course, be understood that following the usual precedent, THE JOURNAL does not necessarily endorse the views of a writer on any subject, only assuming responsibility for what appears in the editorial columns. The value and interest to State journals of the news items department is discussed elsewhere.

The collaborators on the staff of THE JOURNAL intend to abstract from the current literature those articles that are of especial interest to the profession of the State. Their work, which has already been most painstaking, will contribute not a little to the attractiveness and success of THE JOURNAL.

Another factor in the success of a medical journal is in not only the quantity but the quality of its advertising pages. We have already announced our policy in this connection but may say further that while we expect our readers to support the advertiser we are also going to protect our readers and they may be assured when they read a statement in our advertising columns that we have satisfied ourselves all is as it is represented to be.

ORGANIZATION.

The object of nearly all organizations ought to be, and largely, is the betterment of conditions that prevail in the class that form these organizations. Medical organization looks towards the higher standardization of its own body and at the same time to the education of the public as to its participation in the benefits that accrue from better qualified men in the medical profession.

Without medical organization the greatest work of modern times, the building of the Panama Canal, could not have been accomplished. Without medical organization, yellow fever and smallpox would still be harassing the people of Cuba, Porto Rico and the Philippines. The object of medical organization is first and without question the preservation of the public health.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION promises to use its strongest efforts in bringing together all the profession of this growing and progressive State, but with all our strenuous efforts, the physicians of the State must rally to our standard and give us the assistance within their power. The pages of THE JOURNAL will contain worthy articles and papers from the very best men in the State and these papers will pay the doctor who reads them intelligently. There are as good men contributing to THE JOURNAL as any in the United States, and Florida has numbers of first-class men in the profession and from these the reading matter of this publication comes. No state or community has a monopoly of the able physicians of this country, therefore THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION is going to be second to no state journal published.

The County Medical Society is the unit of organized medicine and each county in the state, as far as possible, should have a county society. If the number of physicians in a county is too small or too widely scattered to organize in that county, they may become members of an adjoining

county society or even of a society in a county remote from their own. A member of a county society becomes affiliated with the State Association by virtue of that membership and when his dues are paid to his county society, part of said dues are transferred by the Secretary of the county society to the Secretary of the State Association. A membership in a county society also renders the member eligible to affiliate with the Southern Medical Association and the American Medical Association if he so desires.

Every member of the profession in joining a county society should take pride in such membership and use every earnest endeavor to promote the welfare of the society.

If the profession in any county wishes any aid, encouragement and assistance in the formation of a county society, the editors and contributors of THE JOURNAL stand ready and willing to offer their services in any possible manner.

NEWS MATTER.

THE JOURNAL invites correspondence with the profession of the State in regard to items of news among the physicians, such as announcing the attendance on post-graduate courses, the visiting of the large clinics of this country or abroad, marriages, births, deaths, etc.

It will be a source of gratification to learn through THE JOURNAL that your fellow practitioner in another part of the State has been able from his multitudinous duties to take a few weeks' off for study and recreation.

These items will help to keep in touch with the moving and acting profession and add interest to our intercourse when assembled in our annual meetings. They will make us better acquainted, more friendly and less jealous and bigoted. No physician knows all medicine and sometimes the most exalted may obtain a bit of knowledge from the most humble.

Consider these news items your special page in *THE JOURNAL*, contribute thereto and let us make this department one of pleasure and profit.

OUR CORRESPONDENTS.

We doff our caps to you boys in the trenches—the members of the county societies. This *JOURNAL* was launched for you because you need it. Tell us your joys and sorrows, your hopes and fears, your successes and failures. Let us share your elation

and condole with you when cast down. We can not promise to print all you write because our space is limited but we will cull what we can not use. Have something to say, say it and quit.

We are far away from many sections of the State and can only know what is happening when you tell us. All County Secretaries are hereby appointed official reporters of medical news from their respective counties. Tell the news and let everybody strive to make this department a live one.

Review of Current Literature

A DISCUSSION OF POTT'S FRACTURE WITH COMPLICATIONS.

Speed, Kellogg: A discussion of Pott's Fracture with Complications; based on a series of 208 cases. Surgery, Gynecology and Obstetrics, July, 1914, Vol. XIX, page 73.

Speed in his discussion of Pott's fracture calls particular attention to the fact that there are relatively very few typical Pott's fractures as described in the text books. He finds that in a majority of cases the site of the fracture of the fibula is close to or involving the external malleolus. He particularly emphasizes the necessity for careful radiographs in the lateral as well as the anteroposterior plane. Anteroposterior skiagrams frequently do not show lipping fractures involving the tibia or partial dislocations at the tibio-astragaloid articulation. Speed states that the treatment for all ankle fractures should be prompt reduction under anesthesia with fixation according to the indications of each individual case. Frequently, in spite of every care, manipulation and fixation are insufficient and later and operative procedure is necessary to provide a thoroughly useful ankle. He summarizes his investigations as follows:

"1. Ankle fractures are relatively numerous and have much influence on the wage-earning power of laboring people.

"2. Pott's fracture as classically understood is very rare.

"3. Each ankle fracture should be treated in accordance with the most searching diagnosis, aided if possible by skiagrams, and not by routine method.

"4. Too much faith should not be given to anteroposterior skiagrams through the ankle mortise. Lateral views should be made to show the correct position of the astragalus in the anteroposterior axis and to reveal lipping fractures.

"5. More emphasis should be laid on the treatment of fracture of the external malleolus with or without ligamentous damage on the inner side of the ankle by over-correction in extreme inversion on a splint or in a cast.

"6. Special attention should be paid to the cases with posterior or anterior displacement of the foot, as these indicate lipping fractures of the tibia or complete separation of the external malleolus with loss of support of either anterior or posterior tibiofibular ligaments. Operation should be considered in these cases, particularly to obtain the best result.

"7. Operative measures, of simple replacement, nailing or other procedures, give perfect anatomical results in selected cases.

"8. Use of the foot should not be permitted until pain is not caused."

E. N. Eisendrath, in his discussion of Speed's paper before the Chicago Surgical

Society, stated that patients with fractures of the malleoli with accompanying laceration of the lateral ligaments are almost always allowed to step on the foot too early. He believes that if the patient is allowed to walk four weeks after injury the result is often an impairment of motion with a traumatic flat foot, and that many of these cases have been disabled for months because surgeons have neglected to think of laceration of ligaments as well as fractured bone.

Speed, in his closing discussion, pointed out that if a picture is taken four or five weeks after a fracture the bone seems to be firmly united with the callus in good shape, but that if the patient does heavy walking often the callus loosens and deformity returns; that a patient should have prolonged immobilization or support until the ligaments have firmly united.

ORIGINAL SURGICAL USES OF THE BONE GRAFT.

Albee, Fred H.: *Original Surgical Uses of the Bone Graft. Surgery, Gynecology and Obstetrics*, June, 1914, Vol. XVIII, page 699.

Albee's excellent paper is a resume of his experience gained from 253 human bone graft cases. The possibilities of the bone graft and its extensive range of application is probably but little understood or appreciated by the profession outside of a few bone specialists. The author emphasizes the fact that specialists in bone surgery are getting away from all types of metallic or unabsorbable agents for fixation in ununited or other types of fracture. The bone graft is being used for this purpose as well as to fill deficiencies in bone or to remedy deformity. Albee has applied the bone graft in "178 cases of Pott's disease, sixteen wedge-graft corrections in case of congenital club-foot, seventeen inlay grafts for ununited fractures of the long bones, fourteen cases of paralytic foot deformities; the remaining twenty-eight cases include bone-graftings for fixation of tubercular ankle, repair of osteomyelitic cavities, transplanting astragalus for absent head and neck of femur, the correc-

tion of paralytic drop-wrist, deformity of the tibia following fracture, underdevelopment of the jaw, fixation of tubercular knee, reenforcing the bony deficiency and muscular weakness in spina bifida, in conjunction with arthroplasty for paralytic dislocation of the hip, congenital dislocation of the hip, paralytic scoliosis, restoring depressed nasal bridge, fixation of tubercular sacro-iliac joint, ununited fracture of the spine, ununited fracture of the femoral neck, congenital absence of the tibia, replacing bone deficiency following removal of osteosarcoma, mobilizing ankylosed hips and carpus by the use of osteocartilaginous grafts."

Attention is called not only to the necessity of maintaining an absolutely aseptic technique but to the necessity of having an adequate armamentarium. "The execution of the bone graft in many of the conditions enumerated above would be difficult, slow and inexact, except for the adaptation of the electric motor and attachments, such as special twin saws, drills, burrs and doweling instrument. These save time, avoid traumatism both to bone and soft tissue, favor precision in moulding the graft and preparing its bed, simplify and make easier the technique in deep wounds and regions difficult to get at with hand tools.

"A rapidly revolving motor instrument, according to Crile's kinetic theory, should diminish shock on account of the lessened excitation of the afferent nerves from a rapidly moving instrument and consequently the minimum resultant disturbance to the nerve centers.

"From clinical observation it is apparent that whatever shock occurred when hand bone-cutting instruments were used has largely, if not entirely, disappeared since the development and use of the motor instrument. Whether this is due to the marked shortening of the time of operation or to Crile's theory or to both, and in what proportion, it is very difficult to demonstrate."

While it is true that with small grafts the periosteum and endosteum may be disregarded, Albee concludes that with large grafts "the endosteum marrow substance and periosteum should be included on the graft, as they play a most important role in aiding to establish an early and sufficient blood supply from the recipient tissue to the cortical graft."

"A rapid and complete union between graft and recipient bone should be, in many cases, enhanced by the interposition of numerous small grafts in which the periosteum may be disregarded because of the easy access of blood supply to their anterior osteoblasts. These coalesce with each other and also with the recipient bones and the large graft."

"The bone graft apparently acts always as a stimulus to osteogenesis to the bone into which it is ingrafted or contacted."

The author strongly favors "the substitution when feasible of the bone graft in place of all internal metal splints, especially when it is appreciated that metal has the opposite effect to the graft, in that it inhibits callus formation, produces bone absorption and favors infection.

"The dowel, the inlay and the wedge bone graft afford a means of repairing and remodeling the skeleton which the surgeons has not hitherto possessed."

COMBINED USE OF ADRENALIN AND PITUITRIN.

P. Rohmer presents an article on the above subject in *M. Med. W.*, June 16, 1914. He writes:

"The intravenous injection of adrenalin raises blood-pressure for a comparatively short period only. This rise is followed by a fall to below the initial pressure, and may prove fatal. A subcutaneous injection, because of its local action, permits only a small percentage to reach the circulation, while about 94% is locally destroyed. This is the reason why comparatively large doses can be used subcutaneously over an extended

period with apparent impunity. A previous or simultaneous hypodermic injection of pituitrin, even in a dose so small that alone it exerts practically no action, enhances the action of adrenalin in a most welcome way by increasing and prolonging its action, and by preventing the low drop in pressure that so regularly occurs when adrenalin is used alone.

"Recently a group of children presenting severe cardiac weakness during infectious diseases (pneumonia, typhoid, diphtheria) were most satisfactorily tided over with adrenalin and pituitrin injected simultaneously. The small children received .25 cc of the ordinary pituitrin solution, and .50 cc adrenalin solution. Older children received double the above doses. The injections were generally repeated every six hours. Some of the cases received between doses hypodermics of camphor or caffeine, or both.

"In a case of diphtheria the severe cardiac complication was thus treated for twelve days. Several interruptions were made in the treatment, during which time dependence was placed on other stimulants than the adrenalin and pituitrin. Their resumption, however, soon became urgent and was followed by the happiest responses."

CASE OF DIABETES INSIPIDUS TREATED WITH PITUITRIN.

Hoppe writes in *M. Med. W.*, June 30, 1914: "Considering anatomic findings and experimental investigations, it was assumed that diabetes insipidus might be the result of a disturbance in the pituitary gland. In the reported typical case of diabetes insipidus hypodermics of pituitrin reduced the diuresis to normal, increased the specific gravity of the urine up to 1020, and reestablished the activity of the sweat glands. The intense thirst was also relieved.

"A precious course of atropine injections had reduced the diuresis, but failed to increase the specific gravity of the urine. The thirst was increased. The result was that

shortly the patient manifested signs of edenia and uremic symptoms.

"In this case pituitrin seemed to act as a specific, thus lending weight to the supposition that diabetes insipidus is due to a disturbance in the pituitary gland."

THE PATHOLOGY AND TREATMENT OF CHRONIC LEUCORRHEA.

Arthur H. Curtis: *On the Pathology and Treatment of Chronic Leucorrhoea.* Surg., Gyn., and Obst., Vol. XIX, No. 1, pp. 25-30.

Curtis reports the conclusions based on a two years' study of the subject from both the bacteriological and clinical standpoint.

He finds that the vast majority of all chronic, purulent discharges in nulliparous women are consequent to gonorrhoea. In parous women additional factors are puerperal infections and injuries received at labor.

Purulent discharges originate as a rule in the lower genital tract. The endometrium of the uterine body is not usually much involved. Excessive secretion of cervical mucous swells the amount of the discharge and offers a good culture media for bacterial growth.

A considerable number of bacteria common to leucorrhoea have been isolated and studied. Anaerobic bacteria predominate. Gram-positive bacteria are always present. The gonococcus resists positive identification frequently. In a previous report Curtis has reviewed the cultural characteristics of the organisms most frequently found.

In treatment attention must first be directed toward improving the lowered resistance of the genitalia. Systemic disorders must be treated; complicating pelvic lesions, as pustules displacements, lacerations, etc., must be cared for.

Curtis advises against curettage, and the use of douches or tampons.

Treatment of the hypertrophied mucous glands of the cervix is often necessary. This may be a surgical excision, or cauterization by the actual cautery or silver nitrate.

Similar treatment is necessary for old gonorrhoeal cervicitis.

Autogenous vaccines were found beneficial in some cases. A large number of cases are benefited only as long as the vaccines continue to be administered. A smaller number are completely cured or greatly benefited.

The powder treatment in general seems to have a favorable influence but in many cases the improvement was but temporary or lasted only as long as the treatment was kept up. Various powders were used; yeast in various forms, aluminum acetate, and mixtures of aluminum acetate with kaolin, talcum, etc., being some of the powders. The treatment consisted in first cleansing and drying the cervix and vagina, then coating the parts thoroughly with the powder employed. The variety of powder seemed to make but little difference. The powder is of value probably on account of its absorptive action. Irritating discharges are absorbed by the powder and the irritated tissues given an opportunity to regain their normal resistance.

RETRODISPLACEMENT OF THE UTERUS FOLLOWING CONFINEMENT.

Austin Flint, Jr.: *Retrodisplacements of the Uterus Following Confinement.* Am. Journal Obst. Vol. LXX, No. 1.

The author presents a resume of the subject based on his hospital records and the examinations of one hundred and forty patients.

Retroversions, he states, may be expected in about twenty-one per cent of all cases unless special measures are taken to prevent them. The etiological factors are the size, weight, and mobility of the uterus after labor; subinvolution; perineal laceration; the dorsal posture and tight binder after the tenth or twelfth day; overdilatation of the bladder and getting up too early.

As prophylactic measures he uses means to favor rapid and complete involution. Hot douches are given daily after the tenth or twelfth day. If involution is delayed ergot,

or ergotin, strychnine and quinine are given. Tampons of tannic acid and glycerine are used after the third week in subinvolution. All lacerations are immediately repaired. The binder is not used after the tenth or twelfth day. All cases assume the knee-chest posture for a few moments each day beginning about the twelfth day.

After the condition occurs treatment varies according to the time after delivery that the displacement occurs. Between the second and third week the treatment is hot douches, ergot, and the knee-chest posture. Between the third and sixth week tampons of glycerotannin are also used. After the sixth week a pessary may be used.

INFLUENCE OF FOOD AND FOODSTUFFS.

Meigs in a "Review on Feeding" in *Am. Journal Diseases of Children*, July, 1914, comments on the views of the different schools of pediatrics concerning the etiology of nutritional disturbances of infants. The author concludes that a general agreement exists that there are two general causes: food or bacterial infection. That in Germany more importance is attached to the influence of food and food elements together with such predisposing factors as environment, hot weather and parental infections, while in America the influence of bacterial infection is still considered as of greatest importance; especially as concerns the etiology of summer diarrhoeas. Yet even in this country there is a greater interest than before in the harmful action of foodstuffs and the resulting metabolic disturbances induced. The author refers to the condition known as follicular enteritis, ileo-colitis, dysentery-like diarrhoea, etc., characterized by fever, prostration, stools containing blood, mucus and pus and a tendency to spread by contagion. That in Germany the theory still prevails in the minds of most writers on the subject that this condition is caused by prolonged injury by food, leading to anatomical changes in the intestines, and rarely is due to specific infection.

While among American writers the opinion is prevalent that this symptom complex is associated with bacterial infection, the author refers to Rietschell, who has written much on the influence of heat on nutritional disturbances. This authority believes the influence of heat as a cause of summer diarrhoea is a direct one, producing injury to the child, and not an indirect one through the spoiling or bacterial infection of milk. Rietschell states that as a result of heat there occur lessened activity of digestive processes, lowered tolerance to all food and a secondary change in the intestinal flora. He refers especially to the harmful effects of indoor high temperature and rejects spoiled milk as an important cause of summer diarrhoea. That the theory that spoiled or infected milk causes diarrhoea is unproven, though occasionally in epidemics dysentery may be transmitted in this way.

In the same article Meigs comments on recent reports of Clock on the treatment of all forms of diarrhoea with lactic acid bacilli. The pertinent statement is made that if this treatment is successful in all forms of diarrhoea it is strikingly at variance with all theories in regard to their etiology.

Kendall is quoted as having shown that in a certain group of infectious diarrhoeas, those caused by the gas bacillus, the administration of lactic acid bacilli is indicated. The author concludes with the statement that "further study and confirmation of Clock's results must be awaited."

OBSERVATION ON THE WASSERMAN.

Thomas and Ivy in the *July American Journal of Medical Science*, in an article, "Observations on the Wasserman," call attention to the marked discrepancies between the results of the Wasserman test and clinical findings in many cases. They claim that this is mostly due to the fact different laboratory workers at the present time have too great a variation in their technique for performing the test, and no regular stan-

dardization for the different reagents used. The writers make a plea for the Wasserman workers to get together.

PELLAGRA DIAGNOSED BEFORE CUTANEOUS SYMPTOMS APPEAR.

Fraser in the *Southern Medical Journal* for July, in an article, "The First Symptoms of Pellagra," lays stress on the importance of recognizing the early stomatitis and gastro-intestinal symptoms of pellagra; in a series of twenty-five cases sore mouth was given as the first symptom; in seven only was the dermatitis the introductory symptom.

INTRADURAL INJECTIONS OF NEOSALVARSAN.

Wile in the *Journal of American Medical Association* (July 11, 1914) in an article, "The Technique of the Intradural Injections of Neosalvarsan in Syphilis of the Nervous System," makes a report of the result from the treatment of fifteen syphilitics with intradural injections of neosalvarsan. A six per cent solution of neosalvarsan in distilled water was used, and one to four drops of this solution was injected into the spinal canal. Classification of the cases treated was as follows: Tabes dorsalis, 7; general paresis, 3; cerebrospinal syphilis, 3; taboparesis, 2. Of these fifteen cases treated two are dead, seven markedly improved both subjectively and in the objective findings in the cerebrospinal fluid.

MODERN LEPROSY vs. BIBICAL LEPROSY.

Hill, A. J. (Public Health Reports, Vol. IV., No. 7), reviews the subject of leprosy, going back into ancient Biblical times, and compares leprosy of the modern days with the disease known as tsaraath or Biblical leprosy and summarizes the article as follows:

Lepra, the modern leprosy, shows its skin lesions in, not under the skin, enlarging slowly if at all, the enlargement in most

cases being far too slow to notice in a week, or even in two. Tsaraath, the Biblical leprosy, showed its lesions, under, not in the skin; if the lesions were in the skin but failed to enlarge noticeably within a week, or at the most in two weeks, the suspect was released. The two diseases are, therefore, converse, as regards these, the essential points of diagnosis of tsaraath. The infectiousness and incurability of tsaraath, supposed to aid its identification with lepra, are nowhere mentioned or implied in the Hebrew accounts. This ancient belief in the identity of the two diseases has undoubtedly added much to the sufferings of the modern leper and should be dispelled as soon and emphatically as possible. Modern leprosy should never be called by that name, but always designated as lepra; and every effort should be made to point out that it is produced by a well-known germ, belonging to the tuberculous group; and is in clinical effect a second cousin, so to speak, to tuberculosis, but much less infectious—a disease to be supervised and prevented from spreading, of course, but calling for no panic-stricken flights from its neighborhood and no especial hardships or cruelty to its unfortunate victims.

THE CONTINUOUS METASTATIC NATURE OF THE SPREAD OF PLAGUE.

Van Loghem and Swellengrebel (*Zeitschrift für Hygiene und Infektionskrankheiten*, Vol. LXXVII, No. 3) give credit to the British-Indian Plague Commission for demonstrating the spread of bubonic plague through the medium of epizootics of plague among rats. As soon as rats have been shown to be the root of the evil it is believed that a campaign against the evil must be directed against the plague epizootic. Elimination seems hopeless as soon as the disease has been established and in order to proceed in the most intelligent manner it is necessary to determine the plague foci by a careful and systematic examination of rats. In the spread by continuity the disease

travels from house to house without skipping. In the discontinuous or metastatic spread of plague one town may be stricken and the immediate vicinity remain free and in another town a little more distant the disease may become manifest even though it is a day's journey from the original focus.

The type of rats studied in this survey were the *Mus rattus*, the field rat, *Mus rattus*, the house rat, and *Mus rattus*, the small house rat. The field rats, whose natural habitat is in the open, were found to harbor only a relatively small number of fleas. The greatest infestation of this species of rats was found during the months of September and October. At the same time an effort to determine the close association of these animals was undertaken by means of a study of blood parasites. The trypanosomes being the ones principally found. The heaviest infestation of these were found to be during August and October.

In the study of field rats captured in houses the percentage of fleas was found to be very much higher, the greatest infestation occurring in July, September, October and November. The study of the house rat shows a greater infestation both with fleas and trypanosomes.

In the course of this study nearly sixty thousand humans were inspected for parasites of all kinds and an exceedingly low number of rat fleas were found. It is, therefore, considered very unlikely that the human being as a carrier of rat fleas plays any important part in the spread of plague from place to place.

CONCLUSIONS.

In the spread of plague by continuity the house rat plays a very important part because of its great activity and its tendency to travel. The epizootic can be carried by a house rat not only from house to house but from village to village. In the metastatic spread of plague the hypothesis of the British-Indian Plague Commission can not

be proven, namely: that infected rat fleas were carried by humans and the disease introduced in this way. It has been found that the epizootic has been spread by means of the house rat which has been transported in ships and on railways. It is conceded, however, that the British-Indian Plague Commission may have had a greater number of infestations with rat fleas than was the case in the study of the epizootic in Java.

NEWS ITEMS.

Dr. R. P. Daniels recently resigned as president of the staff of St. Luke's Hospital, Jacksonville; Dr. R. H. McGinnis has been selected as his successor.

Dr. J. Harrison Hodges, of Gainesville, a Past President of the State Medical Association, was married on June 17th to Mrs. LaVerne Windhorst, of Kissimmee. They sailed for Europe on July 6th and expect to remain abroad until October. THE JOURNAL extends congratulations.

Dr. Raymond C. Turck, of Jacksonville, who recently accepted a commission as first lieutenant and assistant surgeon in the Florida National Guard, has been advanced to the rank of major and surgeon. Dr. Turck has been assigned as surgeon to the First Infantry.

Dr. Louis A. Bize, of Tampa, sends us a postcard from Berlin, which indicates that the genial Doctor is doing some post graduate work in Europe.

Dr. J. L. Kirby-Smith, of Jacksonville, recently left for Chicago where he will remain until the first of October. He is taking up post graduate work during his absence.

Dr. Gerry R. Holden, of Jacksonville, recently left for his summer home at Sugar Loaf Mountain, N. C. Dr. Holden will return home early in October.

Drs. Adamson, Bize and Helms, three of Tampa's representative medical men, are touring the continent this summer prior to the meeting of the Clinical Congress of Surgeons in London. From various

European medical centres they have reported enthusiastically on the various clinics attended, and also on the royal receptions accorded them by the various "big ones." They expect to return home about the beginning of September.

Dr. W. C. Buffalow, of Jacksonville, is spending a few weeks of well earned rest in Virginia. He will return home in September.

Dr. W. W. Farnell, who recently passed the examination before the regular board of examiners, has located at Raiford in Bradford county.

Drs. Levy, Mickler and Robles, three recent graduates, have cast their lot with Tampa. Their many friends here and elsewhere wish them well.

Dr. George Walter, of Jacksonville, is spending some months taking up post graduate work at Johns Hopkins Medical School at Baltimore. Dr. Walter expects to return home in October.

Dr. J. Brown Farrior, of Tampa, has been absent from his eye, ear, nose and throat emporium for the last six weeks on account of severe illness in his family. At last accounts his little daughter was gradually showing signs of improvement from a severe case of typhoid fever. During the most critical period of the child's illness she had in constant attendance her father and both her maternal and paternal grandfathers, Dr. F. J. Searcy, of Tuscaloosa, Ala., and Dr. J. R. Farrior, of Chipley, Fla.; Dr. J. P. Bowen, of Clearwater, where Dr. Farrior's family is sojourning for the summer, is her attending physician.

Dr. H. Marshall Taylor, of Jacksonville, sailed for Europe on the 10th inst. Dr. Taylor will spend a month doing post graduate work in Vienna, returning home about the middle of October.

Dr. L. B. Dickerson, Clearwater, was called to Kentucky early in July on account of the illness of his sister.

Dr. J. P. Bowen, Clearwater, is spending the summer in Chicago, working in several

of the surgical clinics. He will remain until October.

Dr. E. W. Diggett, assistant to the State Health Officer, and Dr. F. A. Brink, bacteriologist in charge of the Pensacola laboratory, have been ordered by the State Health Officer to New Orleans for the purpose of making a study of the methods being used there to eradicate bubonic plague.

Dr. C. L. Jennings, of Jacksonville, left the first part of the month for Baltimore and Loch Haven, Penn. Dr. Jennings will return home the first of September.

Dr. J. M. Grantham and family, Tampa, are pleasantly located at Brookline, Mass., for the summer and are enjoying all the historic and other interesting points of that part of the country. Dr. Grantham is spending most of the time at Harvard Medical School in Boston.

Dr. G. E. Tillman, of Bartow, and Dr. A. C. McKenzie, of Palatka, have recently been appointed internes at St. Luke's Hospital at Jacksonville.

The Committee on Legislation and Public Policy held a meeting during the past month in Tallahassee. The chief object of the meeting was to prepare a bill regulating the practice of medicine and to discuss matters relative thereto. The bill which has been carefully prepared will appear in THE JOURNAL in the near future.

The many friends of Dr. P. C. Perry will be pleased to learn that he has returned to his home in Jacksonville and resumed his practice. It will be remembered that Dr. Perry was unable to attend the Orlando meeting of the Association, owing to a severe illness which incapacitated him for a number of months. He has, however, now entirely recuperated, which is gratifying to his friends both in and out of the profession.

Dr. E. W. Warren, of Palatka, secretary of the Regular Board of Examiners, furnishes the following data concerning the recent examination held by the board at Palatka. One hundred applicants were

registered for examination, but only ninety-seven were present. One was refused examination for the reason that he was graduated from an unrecognized school. Of the remaining ninety-six sixty-three were successful in passing, leaving thirty-three failures. Of the thirty-three who failed, four were granted a license under the rule of the board, allowing a credit of one per cent for each year of actual practice subsequent to the first ten years, their credits being sufficient to bring their general average up to the passing point of seventy-five per cent. The States represented at the examination were as follows: Florida, 29; Georgia, 14; Alabama, 14; Illinois, 4; West Virginia, 3; Iowa, 3; New York, 3; Pennsylvania, 3; Louisiana, 2; Ohio, 2; South Carolina, 2; Tennessee, 2; North Carolina, 2; Kentucky, 2; South Dakota, 2; Michigan, 1; Indiana, 1; Mississippi, 1; Texas, 1; Cuba, 2; Jamaica, B. W., 1; British Guiana, S. A., 1; Greece, 1. The colleges were represented as follows: Atlanta Medical College, 29; Meharry Medical College, 6; Memphis Hospital Medical College, 4; Southern College of Medicine and Surgery, 4; University of Georgia, 4; University of Alabama, 4; University of Pennsylvania, 2; Baltimore College of Physicians and Surgeons, 2; University of Tennessee, 2; Birmingham Medical College, 2; Atlanta School of Medicine, 2; University of Louisville, 2; Jefferson Medical College, 2; Barnes Medical College, 1; Leonard Medical School, 1; Rush Medical College, 1; Louisville Hospital Medical College, 1; Chicago College of Physicians and Surgeons, 1; Tulane University, 1; Baltimore Medical College, 1; University of the City of New York, 1; South Carolina Medical College, 1; Starling Medical College, 1; International Missionary Medical College, 1; University of Iowa, 1; University of Michigan, 1; Keokuk Medical College—College of Physicians and Surgeons, 1; Lincoln Medical College, 1;

St. Louis College of Physicians and Surgeons, 1; University of Maryland, 1; University of Illinois, 1; Kentucky School of Medicine, 1; Columbia College of Physicians and Surgeons, 1; Purdue University, 1; George Washington University, 1; University of Iowa, 1; Tufts Medical School, 1; Sioux City University, 1; College of Physicians and Surgeons of Boston, 1; University of Vermont, 1.

NEW AND NONOFFICIAL REMEDIES.

LACTOBACILLINE MILK TABLETS.—Tablets containing pure cultures of the *Bacillus bulgaricus* and *Bacillus paraceticus*. These tablets are used in the preparation of scientifically soured milk. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

LACTOBACILLINE MILK FERMENT.—A pure culture in tubes of the *Bacillus bulgaricus* and *Bacillus paraceticus*. Its actions and uses are the same as those of Lactobacilline Milk Tablets. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

LACTOBACILLINE LIQUIDE, INFANT'S CULTURE.—A pure culture in tubes of the *Bacillus Bulgaricus* in a whey medium. It is employed in the treatment of diarrhea or dysentery in nursing infants or young children. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

LACTOBACILLINE GLYCOGENE TABLETS.—Tablets containing pure cultures of the *Bacillus bulgaricus* and the *Glycobacter peptolyticus*. The *Glycobacter peptolyticus* transforms into sugar the amylaceous substances in the diet, thereby furnishing a pabulum for the *B. bulgaricus*, which in turn transforms the sugar into lactic acid. These tablets are designed for the prevention and treatment of intestinal diseases. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

JACKSONVILLE, FLORIDA, SEPTEMBER, 1914

Number 3

ORIGINAL ARTICLES

THE DIAGNOSTIC VALUE OF ABDOMINAL PAIN IN SURGICAL DISEASES OF THE UPPER ABDOMEN.*

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In the discussion of this subject I shall use the word pain with the utmost latitude. I have no desire to split hairs with any one so I make this explanation at the beginning. As my experience with abdominal surgical diseases goes on I am more and more impressed with the significance of pain, and find myself encouraging my patients to tell me all about their pain, what kind of pain it is and where they feel it, always having them touch the spot where they are apt to feel it most, ascertaining if it is continuous or periodic, how long have they been conscious of it, if it has any connection with the eating of food or constipated bowels, and if they find that certain positions tend to relieve and others to increase the pain. These and as many more questions as are necessary to a clear understanding of the particular patient's pain, because nearly every patient consulting a physician for trouble in his abdominal cavity has pain if the doctor is careful and patient enough to elicit same.

Do not allow your patient to say, as they are so prone to do, "Doctor, I am suffering with indigestion."

"Doctor, I want you to give me some medicine for constipation. I want you to give me something for biliousness," etc. By exercising patience you can elicit in prac-

tically all these cases discomfort, distention, fullness, nagging and dragging, all of which are considered under the caption pain in this paper, or an actual complaint of pain.

Abdominal pain in its most acute form, and in its most prostrating effect, is especially noted in perforation of the hollow viscus. In the initial stages of growths, ulcerations and cholelithiasis it is so mild as to be absolutely ignored by the patient, unless something is done to direct their minds upon it. Colicky pains in the abdomen are distinctive in that they are practically always due to muscle-walled canals and cavities endeavoring to rid themselves of some foreign, irritating material. We must also consider at all times the type of pain known as reflex or referred. A knowledge of the correct amount of importance to attach to referred pain and a careful search for their seat of origin is also necessary to an intelligent diagnosis. It has been said that "the only safe and certain way of properly appreciating the clinical value of a referred pain is not to accept it as the sole suggestive symptom, but only to deem it of corroborative significance when other associated conditions point to the same focus of disease." In order to explain referred pain we must bear in mind the nerve connections between diseased organs and the sensory nerves. On account of the proximity of cells in the cord receiving fibres from abdominal organs to other cells receiving their fibres from the skin, also fibres from these cells to the muscles, and fibres passing upward to the brain, a triple effect is brought about when an abnormal or exaggerated stimulus occurs in the organ. An impression is conveyed to the cells by the

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

afferent nerves that a stimulus has been applied to the sensory nerve endings in the skin; an impulse by the efferent fibres is conveyed to the muscles causing their contraction and in addition the brain is made cognizant of such disturbance in the cells. These referred pains vary greatly in their acuteness and their breadth of distribution on account of the potency of the stimulus in the diseased organ; the relative irritability of the cells in the spinal cord, and the susceptibility of the cerebral centres. It is easy to understand that the severer the lesion in the organ or the primary source of pain, the more acute the referred pain, but the only explanation that can be offered for the relative irritability of the cells in the cord and the susceptibility of the cerebral centres is mainly affected by what is known as constitutional disturbances, whereby not only are the cells directly associated with the diseased organ more irritable, but the cells in their proximity and also cells more remote are similarly affected, that is, the impulse received by the one set of cells overreaches or extends to neighboring cells. The impression is thus carried to the brain that a wider field is involved, the pains are augmented and parts involved not limited to the usual referred pain. Such is the explanation for some referred pains in cases of gastric ulcer and gall stones. At first the referred pain in this disease is ordinarily limited to an area in the epigastrium and right hypochondrium, answering to the peripheral extremity of the sensory nerves sending their afferent fibres to the same group of cells in the spinal cord as the afferent fibres from the stomach and gall bladder. When the pain becomes more widely distributed and is also felt in the side, back, shoulder and even more distant parts we can only conclude that cells other than the ones just referred to have been irritated.

There is a great deal more to be said about pain, but it would constitute a digression from the subject matter and I am com-

pelled to forego such discussion in an attempt to discuss abdominal pain in its relation to surgical diseases of the upper abdomen.

I shall further limit this paper by not referring to any diseases at times medical at other times surgical, such as acute gastric ulcer, atony of the stomach, gastrop-tosis, infantile pyloric stenosis, pylorospasm, etc. The surgical diseases here discussed are those of the stomach, duodenum, gall-bladder, liver and pancreas.

Ulcer of the Stomach. While it is admitted that cases of gastric ulcer presenting no evidence of pain do exist, however, it is a leading symptom in the vast majority of cases. This pain varies greatly in its character in different cases and at different times in the same case. At times the only complaint is of a "sore spot," a sense of pressure in the epigastrium; a sensation of heaviness; a feeling of distention or bloating. Again we are told that the pain is cutting; boring, gnawing, burning or it may be spasmodic and crampy or throbbing. The pain, whatever its nature, is practically always localized in the epigastric region and is, as a rule, increased by pressure. The intensity of the pain at times varies widely in short intervals explainable by the presence or absence of gaseous distention. Different positions, such as lying on the back, face or side, while prone in bed, have an undoubted effect on the pain in ulcer, especially noted by the patient during a paroxysm. The explanation of this is found not in the impact of the gastric contents, but in the displacement, kinking or traction of the pylorus. Patients often complain that when lying on the left side a weight seems to pass to the left. Usually painful lesions of the pylorus during a paroxysm are accompanied by increased discomfort in the right lateral position. In the erect posture a patient frequently bends forward during a paroxysm, or is inclined to sit doubled up; walking increases this pain; exertion, any misstep, coughing or deep breathing all tend

to increase it during the paroxysm. This is explained by the traction and vibration to which the stomach is subjected under these conditions. If peri-gastric adhesions complicate the ulcer the pain is usually to the left of the epigastrium, felt mostly under the costal arch on that side. Pain produced by pressure and percussion is certainly of value in diagnosis, but the painful area must not be accepted as pathognomonic of the site of the ulcer, because gaseous distention undoubtedly increases the intensity of the pain as well as causing it to be felt over a considerable area not corresponding to the diseased spot. The possibility of outlining the site of the ulcer by pressure or percussion would exist only when distention was absent. In addition to the foregoing an area sensitive to pressure or percussion may be found to the left of the spinal column in the region of the 12th dorsal vertebra; also the left flank may be sensitive to fist percussion, while the right is not, contradistinctive to cholelithiasis.

The relation of the pain to food is more complex, because of a combination of mechanical, chemical and thermic factors. Foods causing gas formation produce pain mechanically by distention. This statement is substantiated by the prompt relief often felt after the expelling of flatus; also the benefit received from the application of an ice bag. Vomiting frequently stops the pain right away. Pork, due to its indigestibility, is apt to cause pain by acting simply as a foreign body. Acid foods and strong spices have a chemical bearing in their tendency to occasion discomfort. As a rule, we are apt to find that hot tea with milk, or milk with lime water is kindly borne, while coffee, beer, wine and ice water often induce a painful paroxysm. However, there are no distinct rules for guidance as regards thermic effects. Most often warmth is acceptable to the majority of ulcer cases, but at times it increases the discomfort, whereas the ice bag or a swallow of ice water may temporarily relieve.

Constipation undoubtedly tends to increase the pain of ulcer. This is an explanation of why gentle laxatives, oil enemas or anything that produces a free evacuation of the bowels nearly always brings relief for a time. Most probably the blocking by the fecal masses leads to stagnation in the stomach and increases meteorism, which means pain. It would not seem fair to leave this subject without calling your attention to the tendency of gastropnoxis to aggravate the pain on account of the resulting kinking of the pylorus leading to stagnation with distention and painful traction. In these cases pregnancy is apt to have a beneficial effect by its tendency to elevate the organ.

Perforation. The pain of perforation is affected by the clinical course and for convenience Moynihan has classified these into acute, sub-acute and chronic. In acute cases the pain is sudden, severe and always referred in the beginning to the site of the perforation; the tenderness on pressure is also acute and confined to the point of the ulcer. In sub-acute cases pain is not so severe, but in the early stages is localized in the epigastrium. Chronic cases present less pain yet, but still retain the ear marks of a localization of the point of tenderness early. After peritonitis has developed the whole abdomen becomes tender to pressure.

Cancer of the Stomach. Pain is present at some time in the course of the disease. As an early symptom it is unfortunately not apt to be present except in pyloric cancer. The pain in malignancy is not, as a rule, as severe as in ulcer for the following reasons: (1.) The carcinomatous stomach is less prone to spastic contractions, because the musculature of the stomach becomes atonic very early, whereas the ulcer stomach is hypertonic. (2.) The ulcer stomach is more prone to meteorism especially in the presence of stenosis, functional or organic. In addition to the above the loss of appetite in carcinoma decreases the dietary errors noted in ulcer. One of the most frequent

initial symptoms of cancer is a sensation of pressure in the epigastrium occurring about half hour after eating. It is now taught that this sensation is due to the commencing narrowing of the pylorus which may be a simple functional spasm at this stage. As the stenosis increases the discomfort becomes an actual pain. Pain in carcinoma if present is, as a rule, uniformly present and is not apt to be influenced by an empty or full stomach, thus differing from ulcer.

So far as the localization of pain, subjective and objective, in cancer is concerned, it does not differ materially from that in ulcer. The pain is referred to the epigastrium, lower part of the stomach, loins, back or even the shoulder blades. The areas painful to pressure or percussion are likewise the same, but are not, as a rule, quite so sensitive. The pains depending upon local extension of the process and metastases are differentiated in general by their persistence and their independence of digestive influences. Inflammatory complications also bear directly on the pain and may be local as in peri-gastritis or general as in carcinomatous peritonitis.

Pyloric Stenosis. A discussion of pain in this condition is simply a repetition of what has already been said in connection with ulcer or cancer of the pylorus, the main diagnostic point being that the pain is always of a colicky or cramp-like nature and associated with the sensation "as if there was something alive in the stomach." Great difficulty is experienced in differentiating the pain of pyloric stenosis from that of biliary colic. Some of the most helpful points are: vomiting relieves pyloric cramp, but has no especial effect on biliary colic, in fact it sometimes increases the pain; the pain ordinarily radiates to the right in biliary colic and to the left in stenosis; it comes on at a regular time after eating in stenosis, but, as a rule, bears no such relation to food in biliary colic; certain foods tending to gas formation, increase the pain in stenosis and

have very little, if any, effect in gall-stone colic.

Ulcer of the Duodenum. Moynihan in his book on duodenal ulcer discusses the symptom "pain" in such a masterly way that I find nothing to add. He says: "If the earlier history is well remembered, the patient will say that insidiously, almost imperceptibly, he begins to suffer from a sense of weight, oppression, or distention in the epigastrium after meals. At first the discomfort may apparently be capricious, but it is not long before notice is taken of the fact that it comes usually two hours or a little more after food has been taken. Immediately after a meal there is ease; if pain or discomfort were present before, the meal relieves them, and soon banishes them completely for a while. Then again the pain is felt in two hours, four hours, or sometimes even six hours later. If the pain comes earlier than two hours after food adhesions or stenosis is beginning to develop. A restriction to liquid diet may cause the pain to come earlier. As a rule, the pain comes gradually and gradually increases, becoming more severe and being accompanied by a sense of fullness, distention, "blown out" feeling, and there is an eructation of the bitter fluid or of gas, which affords relief. Many patients will volunteer the statement that the pain begins to appear "when they are beginning to feel hungry," and I therefore suggested in one of my early papers the term "hungry pain" as descriptive of this particular symptom. At first this pain may be noticed only after the heaviest meal of the day, but later in the attack, or in subsequent attacks, it is noticed that after every meal the pain is relieved, only to return in due time. It is a very characteristic factor of the pain that it wakes the patient in the night, and constantly the time of waking is said to be 2 o'clock. For long periods, sometimes throughout the history of the case, the pain remains confined to the epigastrium, but it may strike through to the back or pass around the right side.

When the pain is severe, relief is often gained by pressure and I have known patients wakened in the night to hug a pillow to the abdomen to obtain relief in this way. On some occasions, though this is infrequent, the pain is said to be "cramp-like" in character; a sort of spasm is felt, with exacerbations and remissions, as in all forms of colic."

Careful attention to all the details brought out in the above discussion will almost enable one to make a correct diagnosis from the symptom "pain" alone. It is further to be remembered that these attacks of pain, as a rule, give a definite history of periodicity, and vary in length from two to three weeks up to several months. During the interval between attacks there is an entire absence of pain or discomfort of any kind. Moynihan states that "so complete may the recovery be that the very suggestion that the former attacks have been due to organic disease may be scouted or received with the tolerant smile of disbelief."

Palpation and percussion does not yield much tenderness unless practiced during the time the patient is suffering pain. This tenderness is most commonly just to the right of the mid-line over an area two or three inches in diameter. Moynihan lays stress on the tendency of the winter months in bringing on an attack of pain. I am firmly convinced that this connection is absent or not as constant in the warm countries. It certainly has been absent in my cases, though all his other statements regarding pain in this disease are most pertinent.

Perforation of a duodenal ulcer as is the case in stomach ulcer is announced always by the sudden onset of a severe agonizing pain in the abdomen referred, as a rule, to the upper abdomen. In point of intensity, suddenness and severity no other abdominal pain approaches it except that accompanying perforation of a gastric ulcer. I refer here strictly to the pain announcing the

perforation and not to the pain produced by subsequent complications, which can be prevented by prompt surgical interference. All authorities are more or less agreed that the point of greatest tenderness is located at this time over the site of the ulcer and, therefore, in duodenal ulcer it is found slightly to the right of the mid-line just above the umbilicus. Breathing, coughing, or movement of any kind increases the pain. It has been said that the instant impression of the pain is so great as to cause, in some cases, death. The pain is rarely, if ever, referred to the back and this is of importance in differentiating it from the pain of acute pancreatitis.

Cancer of the Duodenum. This is such a rare disease that I only refer to it on account of its being absolutely surgical. The element pain is present at some time in the disease, but presents no characteristics differing from pyloric cancer. The pain and tenderness are probably more to the right of the mid-line.

Acute Pancreatitis. Hemorrhagic or suppurative. No distinction is drawn between the hemorrhagic and suppurative types because there is no distinction in the pain. In this disease, as in perforating ulcer, the patient is suddenly seized with an excruciating pain in the abdomen generally referred to the epigastrium. Respiration may effect the pain, but not so notably as in perforation. Again, movement does not seem to increase the agony, as these patients are most often found rolling around, turning from side to side or even walking the floor. The pain may be referred to the precordium, or to the right iliac fossa. At times it is quite severe in the loins and back. The point of greatest tenderness to pressure is the epigastrium, although the whole abdomen may be tender. It must be remembered that the general law that organ pains correspond in localization to the organ from which they emanate, applies here and therefore and because of the chiefly left sided position of the pancreas, the pains which

arise in it are most likely to be situated in the left half of the epigastrium, to the left of the umbilicus or even in the left loin.

Cancer of the Pancreas. So far as the study of this disease is known up to the present time it is impossible to offer you anything characteristic in the pain it produces. Some authorities say pain is the most common and earliest symptom, while others claim that it is usually absent or unimportant. If the pain is continuous and ever increasing it has been attributed to pressure on the celiac ganglia; if the pain is colicky it is explained by obstruction of the duct of Wirsung or the common duct. If the head of the pancreas is involved the usual seat of pain is the epigastrium or right hypochondrium, with possible radiations to the back or shoulder. If the growth starts in the body of the gland the earliest pains are most apt to be in the left hypochondrium.

Cysts of the Pancreas. Here again very little dependence can be placed in the symptom pain looking to a positive diagnosis. It may range from a simple feeling of discomfort or distention to attacks of severe lancinating pains. You can't rely much on the localization of the pain. It is usually most severe in the upper abdomen and the patient complains of its being "very deep." It may have radiations to the back, either hypochondrium or to the lower abdomen. There is not, as a rule, any relationship between eating and the occurrence of the pain, although in a few cases it may occur only after eating.

Cholelithiasis. The train of symptoms presented in this disease involves in its ensemble the pain of both acute and chronic cholecystitis, because while pain is the most important symptom in the diagnosis of cholelithiasis, most authorities are agreed that it is due to infection or the result of infection of the biliary tract and never due primarily to gall-stones. For this reason the discussion of pain under this heading

will include its reference to both acute and chronic cholecystitis.

We now recognize in this disease one-type of pain which is mainly referred to the digestive system; also another type which is a colicky cramping pain described as biliary colic. Further one must distinguish between local and referred pain.

As a rule the earliest symptom of cholelithiasis is pain which is always attributed by the patient to indigestion, dyspepsia or biliousness. Not a few medical men diagnose the complaint of these sufferers as gastritis, gastralgia, neuritis or anything rather than gall-stones. The patient describes his pain as dull, burning, gnawing, boring, grasping, etc.; in fact they consistently deny the existence of pain unless the doctor is very painstaking in his examination and questioning. Deaver says: "These gastric symptoms of pain have been described as prodromal symptoms which are said to indicate the impending formation of gall-stones, but later study has shown them to be symptoms caused by gall-stones confined to a gall-bladder in which there is very mild acute or chronic catarrhal inflammation, the latter affecting the gall-bladder alone, while the cystic duct is occluded momentarily if at all, and the to and fro movement of the bile is practically normal. It is recognized as gall-stone pain by the irregularity of its occurrence and by its dependence on no recognized factor. It may occur at night or during the day and be independent of the ingestion of food or of the kind of food." Graham describes these pains as "light attacks of distress, gas, upward pressure, coming often soon after food or at irregular times, often of sudden onset, short duration, eased by belching or perhaps slight vomiting, regurgitation; or slipping away almost unnoticed and without any treatment." The pain discussed here is not the pain we refer to when speaking of gall-stone colic; this pain is never of a colicky nature.

During this stage of the disease while the typical colic has not developed and while it is so important not to err in diagnosis, not only on account of the future suffering that can be saved the patient, but also to prevent the complications that always supervene with time and necessitate a more extensive operation with a higher mortality rate, palpation and percussion very often has to be practiced with the utmost care and very often at different times in order to elicit tenderness. Gentle pressure with the open hand can be practiced without hurting the patient, unless done during the height of an attack and even then a careless examiner might fail to elicit it. The most satisfactory and certain method of demonstrating tenderness during this time is that advised by Naunyn and emphasized by Murphy, who writes: "The most characteristic and constant sign of gall-bladder hypersensitivity is the inability of the patient to take a full inspiration when the physicians' fingers are hooked up deep beneath the right costal arch below the hepatic margin. The diaphragm forces the liver down until the sensitive gall-bladder reaches the examining fingers, when the inspiration suddenly ceases as though it had been shut off. I have never found this sign absent in a case of calculus, or in infectious cases of gall-bladder or duct disease." Naunyn also calls attention to the tenderness of the liver, itself, especially if it be swollen. The pain here is induced when, during a deep inspiration, pressure is made with the hand as far upwards as possible beneath the right costal border. When the liver impinges upon the tips of the fingers the patient experiences a deep seated pain which sometimes radiates over the entire hepatic region and on to the epigastrium. It is important for the physician to remember that the localized pain of cholelithiasis is always relieved by steady, even pressure. Referred pains in cholelithiasis are easily explained by the nerve supply. The three great nervous systems, cranial, spinal and sympathetic

send nerve filaments to the liver and biliary tracts. On account of the general intercommunication of the nerve supply here and various other regions pain occasioned by cholelithiasis and its accompanying infections may be referred to various places, as the epigastrium, right or left hypochondrium, diaphragmatic area, the back, under either shoulder blade, the tip of the shoulder or throughout the abdomen, but the most constant sites are the epigastrium and the right scapular region.

During the early stages of gall-stone disease referred pains are not as frequent nor as pronounced as they are after colic has developed, but careful questioning often brings it out. In this connection I wish to particularly recall to your mind an area of referred tenderness first described and laid stress on by Boas who locates it on the right side behind, on a level with the twelfth thoracic vertebra, two or three finger breadths from the spine. He claims that this tenderness may be present even in the absence of tenderness over the gall-bladder or margin of the liver. He discusses it as follows: "Least recognized as a symptom of cholelithiasis is tenderness over the posterior surface of the liver. To demonstrate it the finger should be pressed against a point to the right side of the tenth dorsal spine; then against successive points in the lines measuring horizontally outward, opposite the other spinous processes, down to the first lumbar spine, first on one side, then on the other. It is then evident which side is more tender. This tenderness, if present during the acute attack, is also invariably present in the intervals; that is, if once present, it is always present, and is, therefore, of special diagnostic value in the latent stages. If there is doubt, after palpation, as to whether the right side is the more tender, greater accuracy may be obtained with the faradic or galvanic current." There is no longer any doubt in my mind of the value of this referred tenderness as an important

diagnostic symptom, having confirmed it repeatedly by operation.

In discussing the pain always referred to as biliary colic, there does not seem to be any generally accepted theory as to its cause, therefore, I leave it to each man to adopt his own ideas until such time as it is finally agreed upon. Very often mild attacks of colicky pain in the initial stages of gall-stone disease are of such short duration that the patient forgets having had them unless closely questioned; also, as a rule, this mild colic is not felt in the gall-bladder region, but in the epigastrium. As often, however, the initial attack is severe and presents the picture of intense agony; the patient is doubled up, pressing his hands into his abdomen or bending over a chair or couch, a cold sweat breaks out, the expression is one of terror and he feels faint and sick at the stomach and often vomits, which at times brings relief. The paroxysm has been known to cause death. This pain is felt in the whole upper abdomen; comes on suddenly, as a rule, and very often passes away suddenly. When the obstruction is not relieved the pain will often last for hours and even days though in this case it does not remain so severe and will then localize in the gall-bladder region, also with pain referred to the back and shoulder. When complete obstruction of the cystic duct occurs, resulting in hydrops, the colicky pain, as a rule, disappears, but if the obstruction is incomplete the colic continues. In this latter class there is frequently noted a referred pain in the right iliac fossa which closely resembles the pain of impacted ureteral calculus. When the obstruction is in the common duct the colicky pain is felt in the right hypochondrium with a referred pain in the right shoulder, the pain often disappears even though the stone remains; explained by a subsidence of the inflammation.

Carcinoma of the Gall-Bladder and Liver. These diseases are mentioned together because the symptom pain does not

materially differ either in its localization, character or its referred areas. Unfortunately the victims of this death-dealing disease are often free from distinct pain until the liver capsule is encroached on or a local peritonitis occurs. Early in the disease there is most commonly just a sense of heaviness, dragging, or possibly a dull ache which is usually felt in the right hypochondrium. With the formation of perihepatic adhesions the pain becomes more constant and may be of a lancinating and sharp character. At this time there are, as a rule, referred pains in the shoulder, back or epigastrium. If the carcinomatous growth causes obstruction in the duct the pain is apt to take on a colicky nature, but it is not distinctly paroxysmal or so severe as the pain of gall-stones. It is worth remembering that movements of the body or muscular exertion excites pain. Tenderness is not present in all cases and, as a rule, requires deep pressure to elicit it. While, as I remarked in the beginning, there are no special points about the pain, yet when considered with the history and other symptoms it has its place of prominence in arriving at a correct diagnosis.

Abscess of the Liver. Though not necessarily present throughout the whole course of the disease, pain is present in practically all cases at some time and it is of diagnostic import that the pain is usually severe at first, gradually subsides in intensity and then becomes more marked again as peritoneal or diaphragmatic adhesions occur. The pain may be paroxysmal, but is seldom throbbing unless the abscess is attached to or penetrating the parietes. At times the pain is described by the patient as simply a heaviness or weight in his side. The pain of liver abscess is most always felt in the right hypochondrium, unless the abscess is in the under surface of the liver when all pain may be abdominal. Referred pain is not a constant symptom in this disease. If present it is most apt to be felt in the spine of the scapula and sometimes radiates to the back

and down the arm. Deep palpation may elicit tenderness over the liver, but it is not to be depended on and in that way differs from the surgical gall-bladder.

Cysts of the Liver. In this surgical disease our symptom pain is not of any value to us through its presence, but is conspicuous by its absence, except in cases where the cyst becomes infected, therefore the absence of abdominal pain aids in a diagnosis by exclusion. At times there is a feeling of fullness or stretching in the hepatic region and occasionally radiation pain of the right scapula. If infection takes place pain and marked tenderness become predominant symptoms.

I have not discussed gunshot wounds or traumatic surgical conditions, neither have I referred to the surgical conditions of the spleen. My reason for this is that it would unduly lengthen the paper and I have attempted to give full attention to the more common diseases. In doing this I wish it known that I have drawn freely from all the highest authorities and I claim nothing original in this paper, but I have at least brought to the attention of this society all the important information that has been gathered by long experience in connection with that most important symptom, pain, and present it in a condensed form for easy reference. A careful consideration of all the details will, I believe, save many an erroneous diagnosis and I submit that as I have spent weeks and hard work in massing this information under one heading, you owe it to your patients to give a limited number of minutes to its careful reading.

ULCUS INTERDIGITALIS FOETIDUM.—If very painful, anesthetize with 5 per cent cocaine. Then apply a pledget of cotton saturated with 3 per cent salicylic acid in alcohol, leave in place five minutes, and replace with dry cotton, which should be changed as often as possible to keep it absolutely dry. This treatment should be repeated twice daily until the ulcer has completely healed. The patient should not walk until he can do so without pain, which is usually in three or four days, and then only limited walking can be permitted and the entire front of the shoes should be cut away.—Nathan Barlow, M. D., in *The American Journal of Tropical Diseases and Preventive Medicine*.

A REPORT OF CASE OF SECONDARY MULTIPLE ECHINOCOCCUS CYSTS OF THE PERITONEUM, COMPLICATING ACUTE APPENDICITIS.*

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Taenia Echinococcus disease in man is so comparatively rare in this country that there are very few of us who have had experience with it. This fact, coupled with other interesting features of this particular case, prompts me to report it.

The Echinococcus, a cestode worm, infects the dog and may be communicated to the human being as the intermediate host through close association with infected dogs, consequently, this disease is most prevalent in countries where there is a close contact between infected dogs and human beings; for example, in Iceland, where people and dogs are frequently housed in the same compartments. In some parts of Asia, and also Australia, the disease is prevalent, but is quite rare in North America. Lyon's statistics, 1902, quoted by Osler,¹ show that there have been only 241 cases reported in North America, only one of these occurring in an individual native to this country. The others were of foreign birth, and 56 of them occurred in a colony of Icelanders, who live in Manitoba. Dogs are rarely infected in America—only one having been found by Curtice in Washington.

A few words regarding the development of the parasite is perhaps not out of place here. The Echinococcus, while it has its natural habitat in the intestinal tract of the dog, requires an intermediate host for the development of its life cycle. Man, the ox, the sheep, or the horse, may become the intermediate host. Its physical characteristics are those of a segmented worm about four to five mm. in length, and is composed

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

¹ Osler, *Prac. Med.*, Eighth edition.

of from three to four segments, the last segment only becoming mature, is about 2 mm. in length, 0.6 mm. in diameter, and usually contains about 5,000 eggs. The head has a rostellum surrounded by a double row of hooklets, and four sucking discs. When the ovum becomes discharged from the dog and is accidentally ingested by man, the capsular membrane becomes dissolved by the alimentary juices, and the embryo, with its one sucking disk surrounded by six hooklets, by which it burrows through the wall of the alimentary tract, may enter the peritoneum, or muscles, or may enter the portal vein and thence be carried into the liver, or it may enter the systemic circulation, and become deposited in the brain or other organs. Having been thus deposited it immediately loses its hooklets, and develops into a cyst, composed of an outer laminated membrane, and an inner granular parenchymatous endocyst. Within this mother cyst there are formed daughter cysts, which arise from buds springing from the granular endocyst. These daughter cysts become detached from their point of origin from the endocyst. They contain the same structural elements as the mother cysts, and are capable in the same manner of reproducing grand-daughter cysts.

From buds of the parenchymatous endocyst membrane also spring germinal capsules which form scolices, which in reality are the heads of the *Echinococcus*. The scolices are composed of a rostellum surrounded by a double row of hooklets, and four sucking discs. They are capable of development into the *Echinococcus* in the intestinal tract of the dog.

The disease then manifests itself in the form of cysts, there being a mother cyst which may contain numerous daughter cysts, growing to considerable size, also fluid containing scolices and detached hooklets. The surrounding parts are usually protected from direct contact with the cyst wall by the formation of a fibrous investment, due to the irritation of the presence of the cyst.

Echinococcus cysts may occur in most any organ of the body, but in perhaps the larger percentage of cases they are found in the liver.

In the case which I am reporting, the original infection was in this region, where it was operated upon, during which time, my theory is that some of the daughter cysts possibly escaped into the peritoneal cavity and there developed. One, about the size of an orange, was located in the peritoneal cavity in the right lower quadrant, exactly under McBurney's point, where it was attached to the greater omentum, and the appendix. The other, and larger one, was situated in the pelvic cavity, posteriorly, involving the posterior parietal peritoneum, and was about the size of a grapefruit, except that it was of an oblong shape, and almost filled the space between the bladder and the hollow of the sacrum.

Case report. P. N., Greek, male. Age 45. Married. Occupation, diver for sponges, which occupation he has followed for 28 years. He lived in Greece for 37 years and then in Tarpon Springs, Fla., going there direct from Greece eight years ago. While living in Greece he fished for sponges off the African coast. He had the usual diseases of childhood, also an attack of tertian malaria. Three years ago he began to complain of an enlargement and pain in the region of the liver, together with symptoms of indigestion, for which he entered the French hospital in New York for treatment. A diagnosis of liver trouble was made, and an operation done, at which time an *echinococcus* cyst of the liver was found. The cyst was evacuated and removed, and the wound closed with drainage. After having discharged for seven months this wound closed, and for some time afterwards the patient was in fair health until about a year ago. At this time he began to complain of mid-abdominal pains which radiated over the right lower quadrant. Nausea was present, also fever and vomiting, together with other symptoms of acute appendicitis,

a diagnosis of which was made at that time. The attack followed the usual course of acute appendicitis without suppuration. After the symptoms subsided, he was in fair condition, except for some digestive disturbances until about the first of November, 1913, when he was again taken with acute abdominal pain, nausea, vomiting, high pulse, rise of temperature, and later a mild leucocytosis. A physical examination three days later revealed a mass, more or less resistant, directly under McBurney's point. A diagnosis of probable periappendicular abscess was made, and an exploratory operation advised.

A right rectus incision was made, and the appendix was found to be in a state of acute inflammation, swollen, very red, with some recent adhesions, but without perforation or gangrene. Adherent to it was a mass as large as an orange, which was more or less movable, attached to the greater omentum, the surrounding intestines and anterior parietal peritoneum. The appendix was removed in the usual way, the mass brought up and easily separated from its attachments, which were not firm except those to the omentum. The mass was removed, and proved to be an echinococcus cyst containing many daughter cysts. The peritoneal cavity was then explored for other cysts, the second being found as has been above described. It was firmly fixed to the pelvic wall, and no attempt was made to remove it as a whole, but after having surrounded with gauze packing, it was carefully opened and contents evacuated, being careful not to lose any of the daughter cysts within the peritoneal cavity. After the evacuation of the contents consisting of numerous daughter cysts and much fluid, the mother cyst was curetted out of the fibrous capsule, the latter packed with gauze, saturated with sterile vaseline, and the wound closed with drainage. The patient has gone on to an uneventful re-

covery, and at this time there only remains a small fistula which discharges very little serous fluid.

It will be noticed that the first cyst, involving the omentum and appendix, was enucleated in toto, the accomplishment of which was quite easy, due to its situation. In the second or pelvic one, the cuticula, or laminated layer was curetted out of its fibrous, or connective tissue investment, for the reason that it was not practical to remove it in the same manner as the first.² P. Buckley states that the so-called investment, or capsule, is really the ectocyst, and is derived from the cyst itself instead of the organ or tissue in which it lies. He also states that it is not sufficient to remove the endocyst alone, but that the capsule must also be removed. It would be quite ideal in my opinion, when practical, to remove both cyst and capsule in their entirety, and even close the wound without drainage, which I would have done in this case except for the conditions present about the pelvic cyst.

Upon further inquiry, after the operation, into the history of the patient, the information was obtained that for several years he was closely associated with a number of dogs which he had at home in Greece, more than ten years ago. It was also discovered that one of his cousins had had the same trouble in Greece many years ago, and that this individual had also close contact with dogs.

The presence of multiple echinococcus cysts within the peritoneal cavity, giving rise to no symptoms until the appendicitis arose, and the possibility of the peritoneal cysts being secondary to the liver cyst and not original infections, constitute the interesting features of this case.

For the history data, I am indebted to Dr. A. Peppas, of Tarpon Springs, Fla., who referred the case to me for operation.

² Brit. M. J., 1913, II, 725 Abst. by Surg., Gynec. and Obst.

MALIGNANT TUMORS OF THE JAWS.*

RAYMOND C. TURCK, M. D., F. A. C. S.,
Surgeon to St. Luke's Hospital.
Jacksonville, Fla.

The classification, differential diagnosis, or treatment of cancer of the jaw is entirely insignificant in comparison with the problem of early recognition. As in other cancers, particularly the sarcoma and carcinoma, the earlier treatment is instituted the greater the percentage of operative cures, and in this connection I want to especially emphasize the fact that the only cure for cancer, with the possible and single exception of early skin cancer, is by operative removal, and this, it should always be understood, means operation in the pre-cancerous stage of tissue change, or in the very earliest stage of cancerous growth.

A majority of surgeons believe today, when cancer of the deeper tissues has progressed to a point where it is possible to make a positive clinical diagnosis, that cure by operation or any other means is highly improbable, if not impossible, and that while through radical operation, use of radium, X-ray, cautery, etc., life may be prolonged, life cannot be saved.

Cancer always gives some warning of its approach, and it almost never begins as a cancer. There is always some harmless tissue change, some little persistent swelling, tumor, enlarged gland, mole, wart, ulcer, chronically inflamed area, scab, unhealed wound, lump or something unusual and abnormal, something unhealthy in a healthy spot. This is as true of other parts of the body as of the mouth, tongue and jaws. While it is true that not every one of these conditions produces cancer, yet cancer when it does come always starts from some such insignificant and primarily benign condition. The deduction is obvious; remove the foundation and thus eliminate the possibility

of cancer. An ounce of prevention is worth a ton of cure, even a ton of radium at fifteen thousand dollars a grain.

In the vast majority of cases the small beginning tissue changes or growths from which cancer develops may be removed under local anesthesia absolutely without danger and with 100 per cent of certain cures. No harm can possibly be done through early correction of minor abnormalities, while life may be saved in many instances.

Cancer may almost be classed as a preventable disease; cure is always possible if the disease is arrested before it begins. Procrastination has killed more patients than the surgeon's knife. Indeed the surgeon does not ordinarily feel, when a patient dies after operation for late or fully developed cancer, that the loss is chargeable to him. The death is due to delay, usually on the part of the patient, the dentist or the medical man who says so often: "It is only a little thing, it does not amount to anything, wait and see if it does not go away by itself," or "if it gets any bigger we will take it out." That is what causes death from cancer, though the responsibility is always placed at the door of the operating surgeon who, unfortunately, usually gets the patient after full development of the disease, and who operates with the faintest hope for cure, in an endeavor to at least prolong life, knowing that he will shoulder blame which rightly does not attach to him but to the preceding procrastinators.

I want to repeat here that when cancers of the jaw, especially myelogenous sarcoma, epithelioma, and carcinoma have progressed to the point where one may say positively that "this is cancer" complete and permanent cure by any means whatsoever is impossible.

The people must be educated to the vital necessity for the prevention of cancer. "It seems unnecessary to present the grewsome, hopeless, agonizing side of cancer, but the

*Read, by invitation, before the Florida State Dental Society, July 3, 1914.

people must be taught about the simple, apparently innocent beginnings which may become cancer. The people must be told that treatment in this earliest stage is devoid of danger, gives little or no discomfort, and that even those operations which they may consider extensive involve a minimum risk and disability. The message is so simple that most people will be disappointed when they learn how cancer is to be controlled. No miracle is needed, unless the education of millions at a time may be considered miraculous." (Bloodgood.)

If an operation is inevitable or even probable it should be done when it is least dangerous and offers the greatest possibility of a cure.

Radium as a cure for cancer has proven most disappointing. Like many other vaunted cures it has not stood the test of time. Far from being the invaluable remedy as was first supposed, it is effective only in a limited number of cases and finds its greatest usefulness in skin cancer and as a supplement to radical operative work.

Recent statistics prove that while a proper dosage of radium undoubtedly has a markedly destructive action on superficial cancer cells without injuring normal tissues, yet it will not reach the deep seated ramifications, and may even stimulate deep cancer to more rapid growth. The use of small amounts of radium is harmful in that the effect is more likely to be stimulating than destructive.

There are a few points regarding the early recognition of cancer of the jaw, which are worthy of more than ordinary consideration. There is always exceeding difficulty in differentiating between benign odontoma and sarcoma, hence Broca's rule should always be remembered, that "Any new growth of the jaw which occurs after complete development of the teeth is certainly not an odontoma." Positive differential diagnosis in youth is often possible only after microscopical examination.

Diagnosis between polyp of the gum and epulis is often difficult; polyp is likely to grow from the margin of the gum into the cavities of carious teeth, while epulis usually extends outward from the spaces between the teeth and often is accompanied by tooth loosening. Clinical distinction between malignant epulis and the benign fibromatous form is impossible except through microscopical examination. The greatest mistake in such cases is to remove the growth and neglect to have sections made for diagnosis. Should the tumor prove to be sarcoma simply removal is insufficient. The underlying bone and often the adjacent teeth and alveolar process must be removed as well.

"The diagnosis of hard periosteal sarcoma which develops at the surface of the jaw from the onset does not occasion any great difficulty. These tumors begin to develop as small, hard, usually round nodules upon the outer or inner surface of the lower jaw. In general they cause only slight pain, and their serious nature is brought to notice only by their growth, the loosening of the teeth, and the difficulty in chewing and speaking. In distinction to tumors these new growths are characterized by their rapidity of growth. At times, however, they at first remain for a long time unchanged, and then suddenly increase rapidly."

"The early diagnosis of myelogenous forms is more difficult. In the upper jaw these new growths frequently are masked by the symptoms of sinus affection. In the lower jaw the bony wall, being slow to yield, obscures the onset of the disease. Only the swelling of the jaw and the breaking through of the tumor explain the dull pains which have frequently been felt in the interior of the jaw for some time." (von Bergman.)

Carcinoma of the jaw may be either a primary growth or secondary to cancer in adjacent structures; a large percentage are

preceded by acute or chronic disease of the teeth, or gums, or may arise from points of irritation from ill-fitting plates, etc.

"The most frequent and at the same time the first symptom is pain. The latter is not characterized by location or intensity. Sometimes it occurs as a violent toothache; at other times as a dull pain in one-half of the face which occasionally radiates to the ear, neck, or back of the head. In carcinoma of the upper jaw a relatively frequent and early additional symptom is obstruction of one nasal passage. Upon digital examination through the mouth the region of the posterior nares and the nasopharynx is filled with soft, gelatinous tumor masses. It is easy to understand, therefore, why many patients are at first treated by dentists and nose specialists. Unfortunately, while the teeth are extracted and polypi removed, nothing is accomplished and the favorable opportunity for the thorough operative excision of this dangerous disease is lost." (von Bergman.)

It does not require an extended study of jaw tumors to demonstrate the facts that diagnosis between malignant and benign forms of new growth is difficult if not impossible; that it is vitally necessary to remove all such growths at the earliest possible time; that after removal the tissue should be immediately examined microscopically to determine whether or not further work is necessary, and that procrastination and delay are but gambles with death.

THE DIGESTIVE SYMPTOMS OF PELLAGRA.—There is no disease or condition with which I am familiar in which the confidence of the patient is more important than in pellagra. Pellagrins are often depressed, and regular, systematic encouragement is necessary to get the patient's cooperation in the building up process that is essential for improvement and recovery. The general impression that pellagra is an almost hopeless disease is, I am sure, responsible for much of the depression and not a few of the suicides in pellagrins. Suggestion and DuBois' method of re-education has in many cases given me better results than any form of medication.—Seale Harris, M. D., in *Southern Medical Journal*.

REPORT OF SIX CASES OF PELLAGRA IN ONE FAMILY.*

J. L. KIRBY-SMITH, M. D.,
Jacksonville, Fla.

Through the kindness of Dr. Ralph Smith in referring the patients to me, I have the opportunity of bringing before your attention six clear cut cases of pellagra occurring in one family in the vicinity of Jacksonville. A few weeks ago, accompanied by Dr. G. E. Henson and Dr. A. E. Thompson, a visiting physician of Detroit, Mich., a visit was made to the home of these pellagrins to try and ascertain if there was anything in local conditions that would throw light on this seeming epidemic of pellagra. The general character of the home, the surroundings, and the people were all typical of a Florida "cracker" homestead. Dr. Henson obtained blood and fecal specimens from each member of the family, all of the latter showed the presence of ovae of uncinaria, nothing of particular note was found in the blood smears.

The diet of the family was the same as in all of our country people, consisting mostly of fried foods, canned goods, with very little fresh meats. Cornmeal bread was the principal bread food, the cornmeal being obtained at intervals from a Jacksonville grocery. The only two members of the family who have not shown any evidence of the disease, it is claimed, have not eaten any cornmeal bread. The water supply is from two sources, a spring several hundred yards from the house and a surface well with the pump right up against the back porch in near relation to the kitchen dish water and soiled water from other uses. Horse and cow stables situated about one hundred feet from the house, flies and, judging from the cats and dogs about, fleas as well are on the very best of friendly relations with the family. Of course there were no fly or mosquito screens, and it was

*Read before the Duval County Medical Society, June, 1914.

impossible to formulate any theory as to what particular insect pest was the cause of this epidemic. Now for a few words about the present knowledge of the etiology of pellagra. It is certainly true that the occurrence of pellagra in our southern states is markedly on the increase. Possibly it may be due to the fact that the disease is more readily recognized by the profession and that more cases are being reported, this accounting for the seeming increase. Personally, I believe that the disease is spreading rapidly, and that it is more of a menace to our country than we realize. The disease should be reported to the health authorities, and there should be a more intense effort at reaching the true etiology, for until we do find the cause of pellagra, we are in the dark as to preventive or curative measures that would enable us to control the disease. You will find in the March number of *Progressive Medicine* a summary of all that has been done in recent years in studying the pellagra situation in this and other countries; Jennings and King in South Carolina have made a close study of the various insects whose habitat is in the house, as to a possible carrier of the disease; the conclusions arrived at are that there is very little doubt that pellagra is transmitted by an insect of some kind, and that possibly the diet of the pellagrins may have something to do with the development of the disease. Siler and Garrison, in August, 1913, made a very comprehensive report of their extensive study of pellagra. The following points brought out are of interest: The disease is more prevalent among the country people of the poorer classes; the disease is less prevalent among the negro race; the female is more oftener affected than the male; diet does not seem to have any bearing on the etiology.

In conclusion I submit the following brief history of the six pellagrins: When first seen, April 11, 1914, four of the cases had been affected for only one month, one for one year, and the other for five years,

the later case has a very severe attack, and has been confined to bed for several weeks; in all of the patients there were the usual gastro-intestinal symptoms and stomatitis, preceding the eruptive symptoms. The one of five years' duration has been having bi-annual recurrences of acute symptoms, spring and fall; the cutaneous symptoms in this case being more marked, lesions are present on the hands, face, neck and legs, considerable pigmentation and thickening being present from former attacks; in the other five cases the symptoms were of a milder type, but typical of chronic recurrent pellagra.

TWO RECOVERIES FROM EPILEPSY.

Chronic coffee poisoning being the cause in one case, and developmental factors during a late puberty, complicated with adenoids, the cause in the other.

W. P. SPRATLING, M. D.,

AND

D. C. MAIN, M. D.,

Welaka, Fla.

Cures in epilepsy are so infrequent as to make it of value to commit to literature every cure, as containing possibly some suggestion that might well apply in some other case.

The epilepsy in these cases originated at an age that is quite rare, after the age of puberty, and convulsions arising "de novo" are very infrequent during the next five or six years.

The curve of frequency rises again about the twenty-first year, maternal factors on one side; lues, trauma and alcohol on the other, being the cause of the accession.

Case 1. V. S.—White, male, age 18, weight 174 pounds, height, 5 feet 10 inches. Mentality medium; by occupation, a fisherman; being almost daily in the water, waist to armpit deep, from eight to ten hours at a time, for about nine months in the year.

At times the water was cold and to warm himself he had the habit, for some years, of drinking two or three big tincups of hot black coffee before going into the water; often drinking in the course of a day eight or ten such cups.

After two or three years he began having psychic seizures with no aura.

His face was in a state of constant flush and he suffered all the while from headache.

From this he went on to "grand mal" attacks, with no aura, as often as once a week, invariably at night, which continued for about eighteen months, when he presented himself for treatment. Careful examination led to the conclusion that coffee was the cause of his trouble, and, needing a man for light work, he was persuaded to remain with us for several months.

Appropriate diet was enforced, together with the right amount of physical exercise (two of the greatest factors in the cure of this disease) and under treatment the severe attacks ceased entirely and the psychic seizure gradually, until now, at the end of two years, he is entirely relieved.

Case 2. E. M.—White, male, age 16, weight 162 pounds, height 5 feet 9 inches. Mentality fair; schoolboy, raised on farm.

This case was referred to us by a physician in Palatka.

For one year he had had almost nightly attacks of "grand mal" of such a severe type that his father never left him at night.

Examination revealed what was considered to be a delayed puberty and an unusual growth of adenoids.

The adenoids were removed by C. M. Sandusky, M. D., of Jacksonville. Like many epileptics, this boy was a glutton.

Appropriate diet and treatment caused the attacks to cease immediately and at the end of eighteen months the boy passed from further observation.

Details of examination, as well as of treatment are omitted for brevity's sake, but we will add that the bromides were not used in

the treatment of these cases, but the pure bromine gas in suspension in a heavy oil, together with other ingredients, in a palatable mixture, was used.

The reasons we prefer this preparation to the bromides are, first; no acne is produced, as in the use of bromides. second; it does not derange the gastro-intestinal system, interfering with nutrition, as do the bromides. This interference of nutrition by the bromides causes loss of weight in eighty per cent of all cases where used. third; most important of all, it lessens, in a more evenly balanced way, the irritability of the entire cell mass of the body.

Crystalline substances, like the bromide salts in watery solution, penetrate and pass through animal membranes very readily, and the amount of salts taken up by the cells external to the blood vessels undoubtedly varies to a marked extent. An oil which does not make a chemical solution, its globules being held in suspension only, penetrates more slowly under a better balance, which is more readily sustained.

PROPAGANDA FOR REFORM

BEEF, WINE AND COCA.—This preparation, sold by Sutliff, Case & Co., Peoria, Ill., was claimed to contain about 15 per cent. alcohol and $\frac{1}{8}$ of a grain of cocain to the fluid ounce. It was found to contain 23.75 per cent. of alcohol by the federal authorities and accordingly declared misbranded by the courts. (*Jour. A. M. A.*, June 20, 1914, p. 1981.)

DR. JIROCH COMPANY, A FRAUDULENT CONCERN.—The federal authorities have declared the Dr. Jiroch Company, 533 S. Wabash Ave., Chicago, fraudulent and denied it the use of the mails. This medical mail-order concern sent out a treatment which appears to have been the same no matter what the symptoms reported by the victim. Examination of the four kinds of tablets sent out, in the A. M. A. Chemical Laboratory, showed these to contain ordi-

nary tonic and laxative drugs. (*Jour. A. M. A.*, July 11, 1914, p. 179.)

HICCURA MINERAL WATER.—This was declared misbranded because it was not a natural mineral water as claimed. (*Jour. A. M. A.*, June 20, 1914, p. 1981.)

LIQUID ALBOLENE.—This is a light variety of liquid petrolatum marketed as a proprietary medicine, exploited in an objectionable manner and with more or less misleading claims. It is said to come from Russia and differs from American products in being entirely non-fluorescent—an immaterial difference. (*Jour. A. M. A.*, June 27, 1914, p. 2048.)

LITHIUM SALTS IN URIC ACID DIATHESIS.—There is no reliable clinical evidence that Lithium salts increase the excretion of uric acid by the kidneys, except as they exert a diuretic action. Experimental work has failed to show that lithium salts or the alkalies cause the absorption of deposited urates, gouty tophi, etc. The popular belief as to the action of lithia is founded on a misinterpretation of chemical facts. There is no reason why lithium salts should be expected to favor the solution of uric acid or urates in the tissues, the blood-serum or the urine. (*Jour. A. M. A.*, July 11, 1914, p. 184.)

MALT NUTRINE.—This product of the Anheuser-Busch Brewing Association was declared misbranded by the government authorities because the label claimed that it was a highly concentrated extract of malt, which was untrue. Malt Nutrine was found to contain 1.6 per cent. alcohol and extravagant therapeutic claims were made for it. (*Jour. A. M. A.*, June 20, 1914, p. 1981.)

PROPHYLAXIS OF TETANUS.—The following procedure is advised: Remove every particle of foreign matter from the wound. Dry the wound and treat every part with iodine or cauterize it with a twenty-five per cent. phenol solution and apply a wet pack saturated with boric acid solution or alcohol. Inject as soon as possible, intravenously or subcutaneously, 1,500 units

of antitetanic serum and repeat the injections if indications of possible tetanus arise. In no case close the wound, but allow it to heal by granulation. (*Jour. A. M. A.*, June 20, 1914, pp. 1964 and 1971.)

RAYMOND'S PECTORAL PLASTERS.—These are exploited untruthfully as "positive cures" for whooping cough, bronchitis, etc. (*Jour. A. M. A.*, June 20, 1914, p. 1982.)

ROBINOL.—Robinol is a glycerophosphate mixture exploited by John Wyeth and Brother on the discarded theory that certain diseases are due to a loss of phosphorus from the body and that this phosphorus deficiency is best remedied by administration of glycerophosphates. There is no evidence that glycerophosphates when administered act differently than do inorganic phosphorus compounds. At all events, if phosphorus deficiency really occurs, it would be more rational to supply the needed phosphorus in the form of foods rich in phosphorus such as milk and eggs. (*Jour. A. M. A.*, July 4, 1914, p. 49.)

TOOTH DETERGENTS.—While many preparations are alkaline from the soap which they contain, it is probable that weakly acid preparations are to be preferred. As the antiseptics in tooth powders and washes do not remain in the oral cavity for any length of time, they can not exert any beneficial antiseptic action. Antiseptics may even be harmful in that their periodical application may render the organisms which infect the mouth more hardy and vigorous. (*Jour. A. M. A.*, July 4, 1914, p. 50.)

VACCINE AND SERUM IN HAY-FEVER.—A serum for the treatment of hay-fever is described in New and Nonofficial Remedies. Theoretically there can be no vaccine treatment of this disease for the reason that it is produced, not by bacteria, but by the pollen of various plants. The use of vaccine derived from the micro-organisms found in the nasal secretion are still in the experimental stage. (*Jour. A. M. A.*, July 25, 1914, p. 340.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, 334 St. James Building, Jacksonville, Fla., U. S. A.

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Next Meeting—DeLand—May 12-14, 1915

THE AMERICAN PUBLIC HEALTH ASSOCIATION.

The American Public Health Association will hold its annual meeting in Jacksonville November 30th to December 5th. The Association is composed of Health Officials, sanitary engineers, laboratory workers, vital statisticians, sociologists and other health workers of this country, Canada, Mexico and Cuba. This meeting will be the first held by this Association in any of the South Atlantic States and means much to the state of Florida and the whole South. Much has been accomplished in recent years in the South in the way of sanitary achievements but a great deal remains to be done, and this meeting, bringing together, as it will, the foremost sanitarians of North America in a Southern city should give a powerful impetus to health work throughout this section. Conditions peculiar to the South daily confront our health workers, not a few of them are difficult of solution and unite, in many sections, to raise our mortality rates. The Committee on Program of the American Public Health Association has taken cognizance of two problems of immense import to Southern health officials and have arranged that two of the general sessions be devoted to symposia on the negro and his relations to public health and health organizations, and rural sanitation.

The papers and discussions on these two subjects should be productive of valuable suggestions to Southern health departments. In our own state during the past few years health departments have been formed in a number of small towns and cities where before no organized work was being done for the conservation of health, and now both the medical profession and the laity have awakened to the benefits that may be derived from the application of preventive methods.

We feel that the State of Florida is fortunate in having secured this meeting and

that its value will be reflected throughout the State by unusual health activities.

THE PROGRESS OF THE TIMES.

There is little doubt that the rapid progress in modern civilization is due to the scientific mind, and the science of medicine stands out and is able to proclaim that not a little of this progress can be credited at her door. Even in the distant past she had her share of honor, but in the immediate past can claim the lion's portion. Not only has she made the accomplishment of such an engineering feat as the building of the Panama Canal a possibility but more wonderful than this has extended the span of human life, increasing the possibilities of the human race. In words that ring with truth and sincerity and which should be read by every member of the profession, Doctor Charles H. Frazier,* of Philadelphia, in his address as Chairman of the Section on Surgery of the American Medical Association, stated, "The rapid strides that have been made in the evolution of modern civilization are almost past man's understanding. To the casual observer, the progress of recent times is attributed hastily to the material contributions of the master minds of the industrial world; but a more careful analysis will lead the seeker after truth out of the turmoil and the noise and bustle of the busy centers of population into the seclusion of the laboratory, where, in the quiet of their academic atmosphere, the chemist and the physicist, the geologist and the agriculturist, the psychologist and the pedagogue, the bacteriologist and the physiologist are working out the problems which make it possible for the human race—men, women and children—to live where conditions compel them to work, and not be mowed down by the cruel operation of the law of survival of the fittest."

*Frazier, Charles H., *The Cerebrospinal Fluid as a Problem in Intracranial Surgery*. The Journal, A. M. A., July 25, 1914, Vol. LXIII, p. 287.

SOUTHERN HEALTH EXHIBIT.

As already noted the American Public Health Association, consisting of Health Officers and health workers in every department, will convene in annual convention in Jacksonville, Fla., December 1st to 5th, 1914. Delegates to this convention from every state in the union, and from Canada, Mexico and Cuba will assemble to discuss measures relative to the conservation of health.

In connection with the gathering of health workers a local committee of physicians deem it apropos to hold a Health Exhibit comprising all the material available in the Southern States, where the problems of Public Health may be shown and their usefulness pointed out by speakers versed in the subject; the Exhibit will be known as the Southern Health Exhibit.

Such an undertaking will require much effort and if the Committee secures proper support, the Exhibit will be a credit not only to Florida but to every state in the Southland.

Many a subject is more clearly and properly understood when presented to the visual sense than can possibly be done in any other way. A speaker may be most adept in painting a word picture and his hearers not be enlightened by his presentation of the subject; whereas the visual picture is ever before the mind to be recalled when occasion demands.

Among the many exhibits on such subjects as tuberculosis, malaria, typhoid fever, hookworm disease, pellagra, etc., there will be a collection from the United States Public Health Bureau at Washington, D. C., on the timely subject of bubonic plague, clearly illustrating the ravages of the disease, the manner of transmission and the measures used for its eradication.

We speak for the success of the Exhibit and would particularly urge every physician in the State to attend. The Exhibit will be open from November 28th to December

8th, 1914, at the Morocco Temple, corner Monroe and Newnan Sts., Jacksonville, Fla.

THE COUNTY SOCIETIES.

Before another number of *THE JOURNAL* appears, many of the county medical societies, not holding regular meetings during the summer, will resume activities for the coming fall and winter season. It is specially desirable that reports of these meetings be furnished *THE JOURNAL*. In addition to this, if the present standard of our publication is to be maintained, we must receive original papers from our members. It would, we think, be advisable for each of the component societies to pass resolutions providing that all papers read become the property of the society and be forwarded by the local secretary to *THE JOURNAL* for publication.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION has already demonstrated its ability to increase the membership of the State organization. The limits of the possibilities of *THE JOURNAL* are controlled by one factor, namely, the degree of support you, the individual member, will accord it. Do not fail, however, to remember that whatever is given *THE JOURNAL* will repay the donor a hundredfold.

PRACTICAL EUGENICS.

It has been but a short time since the press and people of this country fed fast and furiously upon the subject of eugenics; and many an attack of politico-sociological indigestion no doubt ensued from an over-indulgence in this new but very attractive pabulum. This, at least, would account for the marked apathy which has seemingly followed in the wake of the preceding widespread interest.

All will probably agree, however, that such an important matter should not be permitted to lie utterly neglected; and it is a matter of especial gratification, therefore, to note that no less a body than "The Alien-

ists and Neurologists of the United States" at their third annual meeting held recently under the auspices of the Chicago Medical Society* gave attention to certain questions of particular importance from the standpoint of eugenics; and adopted resolutions which would if put into effect prove of great practical value toward eliminating and preventing the propagation of future defectives in the human species.

As it is the avowed intention of this scientific body to secure practical results by inaugurating an active propaganda in every state in the Union, and secure legislative enactment for such of their suggestions as may prove acceptable to mark a beginning in the legal regulation of eugenics, *THE JOURNAL* reproduces herewith copies of the resolutions referred to and invites careful consideration of the same by each and every one of our readers:

"Whereas, it is well recognized by alienists and neurologists the world over that certain major factors are the chief causes of physical conditions accompanied by mental derangement and deficiency, and

"Whereas, these major causes are largely, if not wholly, controllable and eradicable, and

"Whereas, these major causes are alcoholism, habit producing drugs, venereal diseases, work in unsanitary and unhygienic surroundings, and hereditary influence including the immigration of the physical and mental unfit.

"Therefore, Be it resolved, First: That we recommend to the proper state authorities, the absolute control of the sale of alcohol until such time as actual prohibition be enacted.

"Second: That the sale of all habit-producing drugs be strictly regulated in all states of the Union.

*Proceedings of the Third Annual Meeting of Alienists and Neurologists of the United States, published by the Illinois Medical Journal, will be ready for distribution October-November, 1914; price \$2.00. Subscription should be sent to Dr. Clyde Pence, Editor, 3338 Ogden Ave., Chicago, Ill.

"Third: That municipal or state control of venereal diseases be established, with proper treatment for indigent patients, to the end that the spread of syphilis and gonorrhoea be prevented.

"Fourth: That, proper, special hospitals for the cure and treatment of alcoholism and drug addictions be established.

"Fifth: That municipal, state and national inspection of labor conditions be regularly maintained and child labor abolished.

"Sixth: That no known defective dangerous to himself and to others, should be permitted to have unrestricted liberty.

"Seventh: That adequate teachings of the principles of heredity and sex life be initiated and fostered in the home with the view to its introduction into the curricula of schools—above the grammar grades, this instruction to be given to the sexes separately.

"Eighth: That the various states pass reasonable and universal marriage laws, that will be reciprocal, in preventing the marriage of the physical and mental unfit.

"Ninth: That a Psychopathic Laboratory be connected with the Criminal Courts, Common Schools, Railroads, Transportation Companies and Public Service utilities, responsible for the actual safety of the general public should have their employees regularly examined as to their physical and mental fitness.

"Tenth: That, inasmuch as state, county and city public health institutions should have as their superintendents, men of highest qualifications, who may devote their best efforts to their tasks, we recommend that all such positions be subject to civil service examinations.

"Eleventh: That in addition to the above, we recommend a nation-wide campaign of education conducted through the public press, university and medical schools, boards of health, state, county and city boards of education, women's clubs and other proper educational mediums, upon the true signifi-

cance of the development—physical, mental and moral—of the individuals and the race and, finally, we recommend that a committee be appointed to promote the enactment of the above resolutions."

FROM OUR CONTEMPORARIES.

The Southern Medical Journal welcomes into the arena of medical journalism this new aspirant for the favor of medical men. If there is any augury of success in a good start it should succeed. In the first place, it takes its stand upon principles that can not fail to win the approval of all thoughtful physicians, in that it will not accept the advertisements of any class of medicine that has not successfully stood the scrutiny of the A. M. A., Council on Chemistry and Pharmacy. This at once places it upon a moral plane far higher than can be claimed by any journal that prostitutes its pages in the service of preparations declared by the Council to be dishonest or inert. Then too, the personnel of its staff guarantees its conduct an ability and breadth that can not be surpassed * * * It naturally adds to the appreciation this journal feels for the newcomer, to know that every member of that staff is a prominent and enthusiastic member of the Southern Medical Association.—*The Southern Medical Journal*.

We hasten to welcome into the fold of Medical Journalism THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, Volume 1, Number 1, of which dated July, 1914, has been received. Unlike our brethren of the lay press we have no jealousies or rivalries. Politics, factional differences, religion, personal profits, do not disturb the medical press; hence, we welcome all newcomers * * * THE FLORIDA JOURNAL starts out splendidly and along ethical lines. Very properly it adheres to the standard set by the Council on Pharmacy and Chemistry of the American Medical Association in accepting advertising matter which comes

under medical and pure food purview. * * * THE FLORIDA JOURNAL is strictly up-to-date. It is well edited; it has timely papers from progressive physicians, a synopsis of the proceedings of the A. M. A., at Atlantic City, reviews of current medical literature and excerpts from medical publications clipped with discrimination.

The Florida Medical Society has lived forty years without a journal and the need of one is evidenced by the editorial statement that of 1,177 physicians in the state only 238 are members of the A. M. A., and 500 members of the State Society. If THE JOURNAL keeps up the gait it starts out with, the society will never be without a live organ in the future and the stimulus it will give the society will be evidenced in a rapidly increasing membership.—*The Journal of the Arkansas Medical Society.*

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION made its initial appearance in July, as the official organ of the Florida Medical Association. Doctor Graham E. Henson, of Jacksonville, the secretary, is also editor-in-chief and has associated with him two editors and a number of collaborators. We extend to THE JOURNAL our congratulations and wishes for success.—*The Virginia Semi-Monthly.*

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION, the latest state medical journal, made its first appearance last month. It contains thirty-two pages of well edited reading matter and sixteen pages of clean advertisements, having decided to maintain a policy upholding the standard set by the Council on Pharmacy and Chemistry of the American Medical Association.—*The Pennsylvania Medical Journal.*

The latest state medical association journal to appear is that of the Florida association, the first issue of which reached us last month. It is a very neat publication and reflects credit upon the membership from

that state * * * This adds one more to the large list of journals published by state associations and is an indication that before long all of them will exhibit this form of representation. We wish the Florida journal success and prosperity.—*Northwest Medicine.*

CLINICAL CONGRESS OF SURGEONS OF NORTH AMERICA.

Notwithstanding the fact that your editor has suggested that I give a brief report of the Clinical Congress which recently convened in London, I shall take the liberty to preface the report with a few remarks on some of the hospitals visited before reaching London.

It was our good fortune to meet Dr. Antonio Soveral, of the Portuguese medical service, who boarded our ship at the Azores Islands bound for Lisbon, where we spent the day as the doctor's guests. He not only showed us the principle points of interest in the city but gave us entree to the larger hospitals, or infirmaries as they are called, which have been under government control since the foundation of the republic.

While two of the larger hospitals were built about forty years ago, the construction as well as equipment will even today compare favorably with many more modern ones, especially the operating theatres which are thoroughly modern. The surgical instruments and appliances, I noticed, were purchased in the United States.

The medical and surgical wards are two story affairs built in the form of a square around a large open court, each ward accommodates fifty patients and not only are well ventilated but are surrounded with wide verandas for convalescents. Each surgical ward has its separate surgical theatre and dressing room. The pavilion for contagious diseases is located some distance from the main hospital as is the tuberculosis ward; sunshine, fresh air and flower gardens seem to have been the paramount issue in the

choice of the locations for these buildings. The grounds even in the heart of the city present the appearance of a well kept park.

It is scarcely necessary to add that every courtesy was shown by both hospital staffs as well as the officers in charge and all the wards appeared to have their full quota of patients, a number of whom were interesting as well as unusual.

In Barcelona as in Marseilles we were accorded only a superficial view of the hospitals due to the fact that, being foreigners without an interpreter or official introduction, access was difficult. From what we were able to see by casual observation the buildings had the appearance of being more or less antiquated. One thing that impressed me, however, was the artistic advertising that invariably adorned the walls or roofs of the private infirmaries, proclaiming in box car letters the name of the attending surgeon or proprietor together with whatever honorary positions he might have accumulated in his illustrious career. I might add in this connection that a number of office signs also contained, together with the name, the various degrees, positions and specialties practiced, which goes to show that either our colleagues across the way have their quota of the loquacious advertiser or else that this method is the accepted form.

It is with some reluctance that I must confess our hospital experience in Paris was limited to observation from one of Cook's sight-seeing or so called rubberneck auto busses, but I understand that this is almost invariably the rule when an American physician has only a week in Paris.

It was with some difficulty that we reached London from Paris, due of course to the impending war with the attendant excitement that naturally accompanied the mobilization of troops. However we finally reached London and were fortunate in securing accommodations at the Hotel Cecil, the headquarters of the Congress. There were at least a thousand visiting surgeons

on the opening day, and arrangements had been so made that after registering, and reading the program or bulletin of operations at the various hospitals, one had but to make his selection, present his registration card to one of the twelve or fifteen clerks, each one representing one or two of the various hospitals, and receive a card of admittance to the theatre for either the morning or afternoon clinics or both.

For the first two days there was a rush for tickets to two or three of the clinics of the more well known surgeons who happen to be in the lime light at the present time, notably Lane, and it was a case of first come first served but after the second day of the session there was plenty of room for all.

While the hospitals are widely scattered as you would naturally conclude in a city of London's proportions, every effort was made by those in charge to assist the visitors in reaching their destination and as a result very little trouble was experienced.

At the hospitals the list of operations was posted and there was no overcrowding for two reasons: First, the ticket system was in vogue, and second, the vast amount of material and the very large number of hospitals, gave opportunity for all visitors to be cared for.

The section on eye, ear, nose and throat had headquarters at the Hotel Savoy and held their special evening sessions in the Savoy ball room, but the daily bulletin included the entire program of all operations and special demonstrations; the Tuesday bulletin, for example, contained a list of two hundred and twenty-five operations conducted by eighty-eight men, covering practically every phase of surgery.

As to the London hospitals some that were visited impress me as do some other foreign institutions, in that they would serve a better purpose as historical relics. However, quite a number, especially St. Bartholomew's, St. Thomas' and the new Kings College hospital (the latter not quite

completed), are modern or have been improved from time to time to keep pace with the rapid improvement in hospital construction, but it was generally admitted that in some respects the technic was not up to the American standard, and I am inclined to believe in the sincerity of a statement made by a very prominent British surgeon in the course of an operation, namely, "That we surgeons in London are kept busy trying to keep up with the Americans."

The evening sessions in the Grand Hall, Hotel Cecil and the Ball Room of the Hotel Savoy were devoted to the reading and discussion of scientific papers by eminent surgeons from North America and Europe.

On the whole the visitors were loud in their praise of the splendid preparation at the hospitals, the vast amount of material demonstrated as well as the uniform courtesy and hospitality accorded by the London profession.

*St. James Building,
Jacksonville, Fla.*

W. PETTUS DEY.

PELLAGRA CONFERENCE, PINEVILLE, KY.

In connection with the Annual Conference of Health Officers for the State of Kentucky, under the auspices of the State Board of Health of Kentucky, at Pineville, Ky., August 18th, 19th and 20th, a pellagra clinic was conducted.

Pineville is a town of about three thousand inhabitants, situated on the Cumberland River, in the southeastern section of Kentucky. There are a number of coal mines in this vicinity; the principal one near Pineville is that of the Continental Coal Company. It was largely on account of the prevalence of pellagra in the mining camps of this section that Pineville was selected as the place for the conference.

Sixty-three cases of pellagra in various stages were present for the clinic. These presented various symptoms and stages of the disease, ranging from the barely rec-

ognizable cases to those which were in the final stages of the disease. Among those who presented themselves for examination were three women whose condition had not previously been diagnosed. They came in principally on account of having heard that a large number of Doctors would be present who would examine patients free of charge and probably give advice in regard to treatment.

The principal complaint in the early stages of the disease would be that they had been out picking berries or doing some other line of work in the sun and had become sunburned. The sunburn did not heal up as had been the experience in the past and many would consult their physician for this reason. Upon being questioned it was found that other symptoms were present, such as a salty taste in the mouth, salivation with drooling, soreness of the mucous membranes principally affecting the tongue; swimming in the head and impairment of vision which in most cases took the form of diplopia, or "going blind" as many of the patients put it. Weakness, depression of spirits and intestinal disturbances would also be found to have been present for some time when these patients were closely questioned. Of the three cases which I mentioned as not having been previously diagnosed it was found that there had been periodic attacks of constipation and anorexia. The more advanced cases of course complained of diarrhea.

A large number of physicians who had a practice in the mining section and some who were mine surgeons presented a number of cases from their practice. They went into the disease in considerable detail, theorizing to some extent on the probable conditions and cause giving rise to the disease and presented the following facts in support of their theories.

The consensus of opinion of the Kentucky physicians was that the disease was communicable but that it probably required some intermediate host or mechanical

carrier. It was generally agreed that no cases of pellagra had been known to develop which had not previously been in close contact with another case. As an instance of this I might cite one of the three cases mentioned above who stated that at the time she first broke out, five other persons were living in the same house and as she put it, ran from her as soon as she broke out with typical skin lesions. All five of these cases later developed symptoms of pellagra with typical skin eruptions.

Two mining camps were cited, pellagra exists in one but has never been known in the other. These are separated only by a narrow stream. The people in both communities buy their food and supplies of all kinds from the same commissary. Many attend the same church, get their mail at the same postoffice and the school children mingle to a certain extent. The community which had no pellagra had sanitary privies or privies which could be considered to be in sanitary condition, while the community which had a large number of cases of pellagra did not take proper care of the excreta. Immediately after instituting sanitary privies and taking care of the excreta in the pellagrous community the pellagra decreased. Following a severe rain storm when the privy vaults in the pellagrous community were broken in and the fecal matter washed over the soil, pellagra increased more than ever before. When these privy vaults were again put in proper condition there was again a decrease of pellagra in the community.

The physician who reported these conditions cited these as an argument against diet as a factor in pellagra. Other probable causes were hookworms and bed bugs. In a series of three hundred pellagrins who were examined all were found to be infected with hookworms. It was stated that nearly all cases examined showed hookworm infection at some time during the disease. An interesting point in this connection was that examination of the stools from advanced or

moribund cases of pellagra did not reveal the eggs in the feces.

On account of having found this very high percentage of hook worms in the pellagra examined thymol treatment had been given to nearly all pellagrins with the result that large numbers of worms would be recovered. Upon examination of the worms after treatment it was found that the worms did not contain any eggs. Similar results had been noted where worms had been recovered at post mortem. For this reason many of the physicians had discontinued the practice of examining the stool for the presence of hookworm eggs for all advanced pellagrins and would administer the thymol treatment as a routine. This would result in very marked improvement in nearly all cases.

Dr. Gaininni, of Straight Creek, Ky., was inclined to consider bed bugs as an important factor in transmission of the disease for the reason that he had noticed bed bugs present in all families where he had treated cases of pellagra. He had also noticed that most of his cases were hookworm subjects but considered the hookworm a contributory factor. He held the view that there was some other unknown factor responsible for the disease which was carried from one individual to another by means of the bed bug.

Syphilis was also mentioned as a probable cause of the disease but from the investigations made and the results obtained with salvarsan treatment it was found that beneficial results were obtained only in those cases which showed a positive Wasserman reaction. The beneficial results from salvarsan injections were not considered of a curative nature but more that of a tonic.

The improvement following the thymol treatment, however, was very pronounced. The cases, however, who were treated in this way would in most instances adopt a more sanitary mode of living and this naturally helped in the continued improvement. Among the methods of thymol treatment various modifications were spoken of from

that of the ordinary course of thymol treatment to that where no preparatory treatment was given; the thymol would be given in the form of salol coated tablets and continued for six or eight successive nights. The only precautions taken in this latter method of treatment was that no fatty or greasy substance should be taken during the thymol administration.

The State Laboratory of Kentucky had made a number of blood cultures but up to the present time the results were considered negative.

In the course of the discussion on pellagra, Dr. Grubbs, of the Public Health Service, spoke of the similarity between pellagra and sprue. The principal point of differentiation being that the skin eruption is absent in sprue and the salivation is less pronounced. The pellagra tongue and mental symptoms are similar.

In regard to hookworm as a cause of pellagra it was stated that hookworm is very prevalent among the natives of Porto Rico while sprue and pellagra are almost unknown among the native Porto Ricans.

Dr. McNeal, of the Thompson-McFaeden Pellagra Commission, gave a very comprehensive discussion on the work of the Commission and stated that the commission had been unable to find that any relation exists between various diets and pellagra. The work of this Commission is so exhaustive that one can state with certainty that corn meal has absolutely nothing to do with the disease. In fact, from the statistics compiled one can show fewer cases of pellagra among those who consume a great deal of corn meal than those who consume practically no corn meal.

The domicile relationship of the development of cases is very interesting. The communities which show the largest number of cases demonstrate that pellagra spreads by zones immediately surrounding the house or cabin where cases exist. The first zone of houses shows the largest number of new cases. The second zone a smaller number

and likewise the third zone and so on. This domiciliary spread is most pronounced in communities where the human excreta is not properly cared for; where the privy vaults are open and where the sanitary conditions are neglected. Cases in well sewered communities are very rare and are found to be important cases. Installation of sewers and proper sanitation is the most important element in the prevention of pellagra.

Dr. McNeal considered the bedbug as being still an open question in the mode of transmission but thought it was a doubtful factor in that the disease was far more prevalent among women than among men while the opportunities are equally great for either sex to be bitten. The Commission has found that the disease is more prevalent among women between the ages of twenty-one and forty-four. It has also been found that the disease is less severe in young children.

The Commission has also investigated the hookworm theory but has found that the hookworm was of low incidence in communities where there are large numbers of pellagrins. It was emphasized that cleanliness and improvement in hygienic conditions resulted in the diminution of cases.

H. HANSON,

Senior Bacteriologist, State Board of Health.

SOURCES OF ERROR IN THE DIAGNOSIS OF PULMONARY TUBERCULOSIS.—Errors in the diagnosis of active tuberculosis can be avoided when we always bear in mind that there is no single symptom or sign which is pathognomonic of this disease. The most reliable criterion for diagnosis is undoubtedly the tubercle bacillus, but in some cases even this may lead us astray, and recently, since the antiformin method is extensively used, the number of errors of this character has enormously increased. In cases showing tubercle bacilli in the sputum, but in which careful clinical observation discloses no symptoms of phthisis, there is always a possibility that some other acid-resisting microorganism has been mistaken for the tubercle bacillus. With the antiformin method of sputum examination, errors of this kind are more liable to be committed, and a single examination of the sputum showing but a few bacilli is to be taken with considerable reservation unless the symptomatology and course of the disease is that of phthisis.—Maurice Fishburg, M. D., in *New York Medical Record*.

Reviews from Current Literature

OIL-ETHER COLONIC ANESTHESIA.

Gwathmey, J. T. Five Hundred Cases of Oil-Ether Colonic Anesthesia. *American Journal of Surgery*, June, 1914, Vol. XXVIII, p. 268.

The author claims many advantages from this method of producing surgical anesthesia, notably absence of shock, respiratory complications and post-operative nausea, and that "the limits of safety are wider than with any other known method."

The improved technic is as follows:

Castor oil one or two ounces should be given the night before operation. In the morning irrigate until the return is clear, and allow the patient to rest for two hours or more.

Preliminary Medication. One hour before operation give per rectum five to twenty grains of chloretone in suppository, or two to four drams of paraldehyde dissolved in an equal amount of olive oil.

Fifteen minutes after the chloretone or paraldehyde give hypodermically one-eighth to one-fourth grains of morphine with one one-hundredth grain of atropin.

For alcoholics it is suggested that one-hundredth of a grain of hyocine hydrobromide be given two hours before, and repeated with one-fourth grain of morphine one hour before operation.

Twenty minutes before operation "the seventy-five per cent ether-oil mixture should be administered very slowly through a catheter to which is attached a funnel, the end of the catheter having been well lubricated and inserted four inches within the rectum, allowing one minute for each ounce given."

"From a large number of cases, we have deduced the rule of one ounce of a seventy-five-per-cent-mixture of ether in oil for every twenty pounds of body weight. For children, a mixture containing fifty to sixty-five per cent of ether is sufficiently strong. Thus we see that, according to the rule stated, an adult weighing one hundred and

sixty pounds will require eight ounces of a seventy-five-per-cent-mixture. No more than eight ounces should ever be given, regardless of the patient's weight. If a patient is too lightly anesthetized by this amount, it is better to supplement by inhalation than to increase the amount to ten or twelve ounces.

"If cyanosis, loss of reflexes or embarrassed respiration occurs, two to three ounces of the mixture should be withdrawn, and irrigation with water should be instituted and maintained until the anesthesia is satisfactory. If the breathing is easy and regular, with the reflexes active, the patient will be found to be relaxed and in surgical narcosis.

"When the operation is completed, the two rectal tubes should be placed in position and the colon gently massaged from right to left, in order to withdraw any of the mixture that remains. The bowels should then be thoroughly irrigated by one or two gallons of cold soapy water introduced through the funnel attached to one of the tubes and allowed to pass out through the other. One of the tubes should then be withdrawn, and two to four ounces of olive oil, followed by a pint or quart of cold water, should be injected into the colon, and the remaining tube withdrawn. The reflexes should be quite active and the patient breathing quietly as he is returned to bed. The patient usually awakens in ten to fifty minutes, quietly without nausea, vomiting, or pain; the analgesia continuing for some time after consciousness is restored."

This method is contraindicated in any pathologic condition of the lower bowel.

"Advantages. 1. In administering ether by this method in bed, every principle of anoci-association, as enunciated by Crile, is fulfilled.

"2. Absence of apparatus of any kind enables the anesthetist to devote his entire time to the patient.

"3. An even narcosis automatically maintained.

"4. Quiet natural breathing, without mucus rales.

"5. Reduction of post-operative vomiting, nausea, gas pains, etc., to a negligible quantity.

"6. Return to consciousness in an analgesic state."

SURGERY IN GOITER.

Wathen, J. R. The Surgical Treatment of Goiter. Southern Medical Journal, June, 1914, Vol. VII, p. 493.

Wathen discusses his experience in three hundred operative cases of goiter. He emphasizes the fact that often in cases of hyperthyroidism, the thyroid gland is but slightly enlarged and, therefore, the true disease is often overlooked. Mental irritability, tachycardia, loss of weight, slight tremor and muscular weakness should lead one to suspect hyperthyroidism. Exophthalmos is usually a late symptom.

Wathen believes that medical treatment of Graves' disease is not only of no permanent benefit, but often is productive of positive harm, not only because of the delay in surgical intervention, but because the usual treatment by iodine, thyroid extract, electricity, etc., often stimulates further thyroid secretion and may change a cystic or adenomatous goiter into the exophthalmic type.

Cases often apparently improve temporarily under medical treatment, but this also occurs without any treatment whatever, and "they often do best if kept quiet and are given no medicine at all."

He states that "if we delay operation for several years, administering iodine and electricity until there is heart muscle degeneration, albumen in the urine, enlargement and fatty degeneration of the liver, lowered blood pressure, etc., we have waited too long to attempt any radical operative measure, and that these patients will generally die."

"The proper time to advise operation with the expectation of a low mortality and good results is after thyroid enlargement has begun to manifest the early symptoms of exophthalmic goiter, and has existed for several months with little or no signs of improvement."

Wathen's mortality in all types of cases has been a little over four per cent. He states that he has apparently cured seventy-five per cent of his cases, and has given some relief to the remainder.

DIAGNOSIS OF DUODENAL ULCER.

George, A. W., and Gerber, Isaac. The Direct Method of Diagnosis of Duodenal Ulcer by Means of the Roentgen Ray. American Journal of Roentgenology, May, 1914, p. 287.

The authors base their deductions on six hundred cases examined by the bismuth serial method. They report seventy-seven cases of duodenal ulcer diagnosed by serial radiographs, and proven by operation. There were but three minor errors of diagnosis in this series and but one serious error was made in the entire six hundred cases. They claim, and their work seems to justify the claim, that through proper use of the X-ray, many gastro-intestinal lesions may be diagnosed as positively as lesions of bone or stone in the urinary tract. The authors claim:

"First: The positive (or direct) method consists in demonstrating adequately the anatomical condition of the first position of the duodenum.

"Second: Ninety-five per cent of duodenal ulcers occur in the first portion of the duodenum.

"Third: Anatomically the first portion of the duodenum is a constant entity.

"Fourth: If normal, the first portion of the duodenum can always be demonstrated on a plate, with characteristic shape and smooth outline. There is no exception to this rule. Apparent exceptions are due to improper technique.

"Fifth: A constant defect in this duodenal cap means a pathological condition.

This may be ulcer, adhesions, cholecystitis, or anatomical or accidental variations, such as pressure of adjacent organs, etc.

"Sixth: Any duodenal ulcer, which is more than a simple mucous membrane erosion, will deform the outline of the bismuth mass. To this statement there is no exception.

"Seventh: A normal 'bulbus duodeni' or duodenal cap on the plates rules out indurated or surgical duodenal ulcer."

PAGET'S DISEASE.

Murphy, J. B. Paget's Disease. *Surgical Clinics*, June, 1914, Vol. III, p. 426.

Murphy, addressing his senior class at Northwestern University Medical School, made the following very pertinent and illuminating comment on Paget's disease:

"Let me mention one disease which is more outrageously managed than any other disease in the mammary gland, and that is the little red nipple which gets a little abraded and then a little more abraded, and two months, three months, six months later becomes a still greater abrasion. You first see a little crust. When you pick off the crust just near the outlet of the nipple, there is a tiny drop or two of blood, not so large as a pinhead. That area slowly increases in diameter, and finally it involves the circumference of the nipple. Then it spreads a little, covering the areola. It gets a little larger, and, finally, some one wakes up and tells the patient that she has Paget's disease, when he should tell her that she has Paget's cancer. Then she has salves, ointments, and applications, and she fools with it another six months, a year or two years, treating Paget's cancer as an eczema. That case is a cancer from the very first day that you see that little sore. It is the most wicked type of cancer which occurs in the breast. That little exudate which comes out and keeps coming is merely the discharge of the necrotic area which develops in that slowly advancing but terrifically malignant disease. Remember, Paget's

cancer has a final cancer mortality of something over ninety per cent as it is operated now. The patient, as a rule, first calls the doctor's attention to it, who treats it with pastes and salves, and it is not operated on until the axillary glands are involved and until the life of the patient is extremely hazarded. Now, if we as doctors know, and if we as doctors recognize, that Paget's disease is always a malignant disease from the very first day, then we should make the diagnosis and should remove the breast as soon as the lesion is discovered. Paget's disease should have a complete amputation of the breast the moment you see that secretion from the nipple, because the small scab is the beginning of a carcinoma, just as much as the crack on the lip or the chronic ulcer of the lip is the first stage of carcinoma. That breast must all come out. If the patient says no, then it is your duty to send her to some one else; but before you do so, make it plain to her that it is a cancer and that the outcome will be fatal if she permits it to remain. You are then fulfilling your obligations. If you are positive enough, the patient does as you require. If you waver—and patients have an instinct which tells them when you are wavering—they do not do as you wish."

TUBERCULOSIS OF MALE GENITO-URINARY SYSTEM.

Simmonds. Tuberculosis of Male Genito-Urinary System. Report on 200 Sections. *M. Med. W.*, June 23, 1914.

The essayist reports on the post-mortem findings in two hundred personal sections. In forty-three per cent genital tuberculosis was combined with tuberculosis of the kidney or bladder. (In females this combination is found in only eight per cent.) In the urinary system the infection begins almost always in the kidney. Within the genital system the infectious process may spread in either testicular or testicular direction. In the combined genito-urinary tuberculosis is presented an encroachment either of the genital process on the urinary system

or vice versa. In the genital system the prostate gland was most frequently involved (seventy-six per cent), next the seminal vesicles (sixty-two per cent), and lastly the epididymes (fifty-four per cent).

In forty cases in which tuberculosis was found in only one organ of the genital system, it was found that the prostate gland was involved twenty times, the seminal vesicles ten times, and the epididymes ten times. The prognosis of genital tuberculosis is bad. Miliary tuberculosis and tuberculous meningitis claims one-third of the cases. Fifty per cent of the male cases that die from tuberculous meningitis have suffered from genital tuberculosis. Spontaneous cure of tuberculosis of the seminal vesicles is very rarely met with. Cured tuberculosis of the epididymis is met with a little more often. In twenty previous castrations in the author's material the prostate gland became involved later twenty times, and the seminal vesicles seventeen times. These should, therefore, be removed in doing castrations for tuberculosis.

DYSMENORRHOEA.

Doederlein, Theo. J., *Dysmenorrhoea Essentialis*. Surgerv, Gynecology and Obstetrics, August, 1914, Vol. XIX, p. 165.

In discussing dysmenorrhoea, Doederlein calls attention to the fact that this condition is much more prevalent among American girls than in their European sisters although many of our working girls come from Europe where they enjoyed good health. In addition to the pain and discomfort resulting from the condition we should not lose sight of the fact that it greatly reduces the economic value of the working girl. He emphasizes the fact that all pelvic pains accompanying menstruation should not necessarily be included under this nomenclature. He cites simple, tubercular, and specific salpingitis; oophoritis of all types; myomata of the uterus, either by pressure or obstructing the outlet; old perityphlitis, and appendicular inflammation, as diseases in which exacerbations generally occur during the

menstrual epoch. "It is obvious to me that the term 'dysmenorrhoea,' really meaning *difficult menstruation*, should be restricted to a certain syndrome of symptoms of specific character; that, in other words, it is a well defined pathological entity, and has a treatment entirely distinct from that of other diseased conditions of uterus and adnexa." In discussing the development of the affliction he records that "it ordinarily appears in virgins who never were exposed to the danger of pelvic infection" and "that in girls who practice sexual relations dysmenorrhoea is rarely found."

He describes the type of pain as a lancinating, colicky one, radiating from the uterus to the back, usually setting in before menstruation commences but occasionally delayed until the flow is established. Characteristic of dysmenorrhoea is the entire absence of symptoms during the intermenstrual period, in contradistinction to most pelvic diseases when the sufferer is aware of a certain amount of disturbance even in this period. Of especial significance in establishing a diagnosis of essential dysmenorrhoea is the extreme sensitiveness of the uterine mucosa, the healthy uterus being not very, if at all, sensitive. In discussing the treatment of this troublesome and painful affliction, he states that it should be considered under two phases—curative and preventive. He dismisses the latter line of treatment from discussion in the article as it "involves a difficult sociological question." He sub-divides the curative treatment as general and local, the former consisting of hygiene, diet, tonics, and the administration of tuberculin or thyroid extract. For local treatment he advises the introduction of intra-uterine stem pessaries of the Watkins or Dickinson type, dilatation and systematic sounding. He considers the main object attained by the use of pessaries or sounding is the blunting of the hypersensitive mucosa and that the results attained by this line of treatment are not due to the dilatation, as was formerly believed.

He treats the attacks by relieving the congestion with hot applications, hot sitz baths and hot douches together with the internal administration of hydrastis, viburnum and opiates for the relief of the uterine contractions.

RECTAL ALIMENTATION.

Goodall, H. W., *Rectal Alimentation*. Boston Medical and Surgical Journal, January 8, 1914, Vol. CLXX, p. 41.

A review concerning the present status of rectal feeding, with special reference to the absorption of nutritive material from the large intestine.

He concludes that little or no digestive process occurs in this organ, the chief function being excretory. About eighty per cent of the water that passes the ileocecal valve is absorbed by the large intestine, but very little absorption of food takes place. Aside from water he states that experimental evidence shows salts to be absorbed from the large gut and monosaccharide sugars to a certain but definite extent. Fats and proteids are either too slowly or imperfectly absorbed to be of any value even when the proteids have been previously acted upon by pancreatic ferments. Alcohol is rapidly absorbed.

According to the author the only rational nutrient enemata consist of water, salts, simple carbohydrates and alcohol. He suggests an enema of the following proportions as yielding the greatest absorption with the least irritation:

Dextrose, 50 gms.

Absolute alcohol, 50 gms.

Water, 1,000 c. c.

If the enema is further concentrated absorption is incomplete.

NEWS ITEMS.

The July meeting of the Leon-Gadsden Counties Medical Society was held in the office of Dr. R. L. Kennedy at Havana. The meeting was called to order by the President, Dr. H. S. Palmer of Tallahassee.

A paper by Dr. Kennedy entitled "Burns; Their Etiology, Pathology, Prognosis and Treatment," and one by Dr. J. C. Davis of Quincy, entitled "Traits and Taints," made up the scientific program. At the conclusion of the meeting the Society adjourned to the home of Mr. and Mrs. G. W. Kennedy, where they were entertained at supper. Those present at the meeting were Drs. Moore, Palmer, Johnson, Taylor and Gynn of Tallahassee, Dr. Diggett of the State Board of Health, Dr. Davis of Quincy, Dr. Wheat of Amsterdam, Ga., Dr. Brinson of Hinson and Drs. Kennedy, Coleman, Howell and P. C. Harrell of Havana.

Dr. J. D. Love, of Jacksonville, returned home the first of September after spending two weeks in Virginia and South Carolina.

Dr. M. A. Lischkoff, of Pensacola, has been spending the summer in New York, doing post-graduate work. He will return about the first of October.

Dr. W. C. Buffalow, of Jacksonville, resumed his practice the latter part of August after spending a month in West Virginia and South Carolina.

Dr. T. M. McDuffie, of Manatee, spent the month of August in Tennessee, his old camping grounds.

Drs. Bize, Adamson and Helms, of Tampa, have returned from their trip abroad. They report having had a splendid time. The great inconvenience of travel in warring countries added many elements of excitement not soon to be forgotten.

Dr. J. E. Boyd, of Jacksonville, was married in Philadelphia on August 22d to Miss Hazel Locke. Dr. and Mrs. Boyd are spending their honeymoon touring in the East. They will return to Jacksonville the first of October.

Dr. Geo. C. Kilpatrick, of Pensacola, is taking a post-graduate course in diseases of the stomach. He has been in Europe since July.

Drs. Strong and Harrison, of Palmetto, entertained the Hillsborough County Medical Society August 18th with an interesting

lecture on and demonstration of a new blood parasite they have discovered in some 70 odd cases of hematuria. A preliminary report of their work is promised for an early number of THE JOURNAL.

Dr. Raymond C. Turck, of Jacksonville, left for New York the latter part of August. He will spend the month of September in the hospitals of New York and Chicago, returning home the first of October.

Dr. Carlisle Robles, of Tampa, left for Atlanta to become interne at the Grady Hospital for six months. At the end of his service he will go to New York to accept a similar service at the French Hospital for a period of eighteen months.

The many friends of Dr. W. W. McDonnell, of Jacksonville, will regret to learn that he was recently compelled to undergo an operation for appendicitis. THE JOURNAL is glad to be able to state that he is making a good convalescence and will soon be able to resume his practice.

Dr. E. W. Warren, of Palatka, has been spending a few weeks in the mountains of North Carolina and Tennessee.

Dr. C. W. Bartlett, of Tampa, and C. T. Young, of Plant City, assistants to the State Health Officer, have left Tampa for New Orleans, where they have been assigned to special duty studying the plague situation and the methods being followed by the authorities to stamp out the infection.

Dr. H. M. Strickland, of Live Oak, was in Jacksonville on professional business during August.

Dr. W. E. Ross, of Jacksonville, is spending the month in Vermont.

Dr. H. Marshall Taylor, of Jacksonville, was compelled to cancel his trip to Europe, owing to the war situation.

Dr. T. Z. Cason has resigned his position as Senior Surgeon of St. Luke's Hospital, Jacksonville, and opened offices at 225 West Forsyth St.

Dr. N. M. Heggie returned to Jacksonville after spending a month's vacation in Baltimore, Philadelphia and Brevard, N. C.

Dr. J. Knox Simpson, of Jacksonville, returned the first of September after spending two weeks at his old home in North Carolina.

Drs. F. J. Bowen and Walter P. Dey, of Jacksonville, returned home the middle of August from their trip in Europe.

NEW AND NONOFFICIAL REMEDIES.

Since publication of *New and Nonofficial Remedies*, 1914, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies":

ARLCO-UREASE.—A standardized preparation of the ureolytic enzyme obtained from the soy bean. It decomposes urea into ammonia and carbon dioxide and is used in the estimation of urea in urine, blood and other body fluids. The ferment is added to a measured amount of urine and, after a time, the amount of ammonia formed is determined. Arlington Chemical Co., Yonkers, N. Y. (*Jour. A. M. A.*, July 11, 1914, p. 156.)

ELECTRARGOL FOR INJECTION.—Ampules containing 10 cc. electrargol in the non-isotonized condition. Comar and Co., Paris, France. (*Jour. A. M. A.*, July 11, 1914, p. 165.)

LACTOBACILLINE SUSPENSION.—A pure culture in tubes of the *Bacillus bulgaricus* grown in a neutralized bouillon medium. This culture tends to inhibit the growth of deodorant, putrefactive and pathogenic organisms and is used externally in various suppurative conditions. Marketed as Lactobacilline Suspension, containing 5 cc., and Lactobacilline Suspension, Surgical, containing 20 cc., in each tube. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

JACKSONVILLE, FLORIDA, OCTOBER, 1914

Number 4

ORIGINAL ARTICLES

THE FAMILY PHYSICIAN AND THE PUBLIC HEALTH.*

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In this time of specialization I have possibly chosen my title poorly, as a strict interpretation would exclude a host of medical men who, though in no sense general practitioners, yet, in each of their lines of work, are hourly occupied with matters closely related to the public health. In the broader scope of health conservative work that is yearly opening up new avenues to the sanitarian, each practicing physician, whether specialist or family doctor, is becoming more evidently necessary to community interests than heretofore, and the fundamental causes of specialization in medical practice have likewise necessitated specialization in the hygiene and sanitation of communities.

To attempt to disassociate prophylaxis and cure would be as irrational as an effort to separate morbid changes from symptoms. It is quite natural that the earliest medical efforts should have been directed at treatment rather than prevention. The immediate exigency will always appear of more vital concern than future considerations. It was likewise natural, indeed inevitable, that preventive medicine should have been the outgrowth of efforts, variously successful, to cure existing maladies, as, through the summing up of individual cases, the reviewing of epidemics and relating conditions alone were made possible the earliest successful efforts for the prevention of disease. The

treatment of the individual and that of the community must always be closely related. As food, occupation, environment and idiosyncrasy affect the individual's proneness or immunity to certain diseases, so are the relations between the aggregate of these influences, sociology, and hygiene extremely intimate.

As an early writer has said, "Communities and nations, like individuals, have their acute and chronic diseases, their fevers and neuroses, their affections of growth and of decay, of infancy and manhood—and so, each race or people, state or city, has its own peculiarities, its constitutional tendencies, which must be taken into account by those who wish to preserve or improve it." It is therefore evident that, aside entirely from any direct effect the application of his knowledge may have on the individual case, the practitioner of medicine must always bear the closest of relationships to the public health. His experience added to his training gives him a perception of community maladies as well as of individual ailments and, as all knowledge involves obligations, he must inevitably assume his share of public responsibility. Public ignorance of matters medical and individual indifference to policies for the common good have united, in the past, to obscure this relationship. Even now the average patient, however grateful for assiduous medical attention when ill and suffering, would probably resent as intrusive and meddlesome, an offer on the part of his physician to supply him, for even a small consideration, with knowledge that might safeguard his health and prevent an illness for the cure of which he would hastily seek medical advice.

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

This attitude, while of recent years gradually changing, renders difficult the employment of certain valuable measures by public officials. In times of apparent safety, preventive measures are too often regarded as needless though obviously more completely effective when put into operation at such periods. It comes then to the private practitioner, in many instances, to render the earliest service to both family and community. In the prompt recognition of communicable diseases and their reporting to the health department is opportunity given to safeguard the community and, through the quality of his advice in the home, are members of the family warned in season or needlessly exposed. The course of action he follows at this time of discovery may determine the health or lives of many individuals, indeed, this early period in the course of transmissible diseases is, in all probability, responsible for more contact infections than any other period.

First, because all of the acute contagious diseases are highly communicable at this time and second, because the family and friends of the patient, as yet unsuspecting of the nature of his malady, are continuing their habitual relations with him. When medical advice is sought in many instances, every member of the family may have been thoroughly exposed, but even so, one of the first duties of the attending physician should be to segregate the case as far as possible. It is generally admitted that close or even repeated contact is frequently necessary to cause infection, except in certain highly contagious diseases, and in direct proportion to the early prevention of this will secondary cases be avoided. Where an organized health department exists and certain diseases are reportable, the practitioner may defer reporting some case, owing to an uncertainty in the diagnosis. Such a procedure is perfectly justifiable providing the situation be explained to the family and instructions given for the protection of its other members. Where, however, protective measures

are not instituted, such delay may occasion needless infection and is distinctly a neglect of professional duty. In such instances valuable time is lost for which no degree of care, subsequently instituted, may compensate.

I appreciate fully that the physician is called upon to attend the patient, that his interest is centered in the case itself and that his time is precious, yet the profound ignorance of the average layman concerning the transmission of disease is such as to command the assistance that may be given in a few words of expert direction and advice. Of possibly even greater importance than the early handling of such cases, as far as the general public is concerned, is the period of carriage which follows certain infectious diseases as diphtheria, typhoid and others. Here especially is the layman quite ignorant and yet no other time so widely threatens the public health. It has been stated that except for human carriers epidemics would be impossible and there is abundant proof that this is true.

The infecting agent, in the vast majority of diseases, does not thrive long outside of its normal host and in the suppression of epidemics I believe that our best hope lies in the detection and proper care of carrier cases. The individuals' natural resentment to protracted quarantine and his proneness to visit his indignation upon the attending physician, renders the latter's duties especially onerous toward the end of a prolonged period of isolation. It is distinctly the duty of health departments, where such exist, to assume this after care but in the smaller communities and rural districts the burden must fall upon the medical attendant. His responsibility here is great; recovery has rendered his visits unnecessary to the welfare of the case and the average patient is not over-pleased to be charged with visits paid in the interest of the public health. These may be largely avoided if the future guidance of the patient is outlined early by his physician, but where necessary to determine freedom from infection the physician's

obligation to the community is surely obvious.

In no line of work may the spoken word be of such vital importance to its hearers as in the practice of medicine. No other educator possesses such power for good or evil or is granted such opportunity, through proper teachings, to preserve health and lives. The field where his teachings will bear most fruit and where at present ignorance claims its greatest toll of human life is among the mothers of young babies. It is well known that the period of greatest mortality is during the first year of life. It is also well established that a very large percentage of the deaths occurring at this period, from one-half to two-thirds, are due to causes insignificant as compared with their effect, to filth, ignorance and carelessness. In the attending of cases of confinement and their after care, the family physician may easily overlook the fact that in confining his attention to the progress of the puerperium alone, he is overlooking an opportunity that will never again be presented in the life of the new citizen he has just brought into the world. On the counsel given to the ignorant mother, during these routine visits, depends a long train of events which, in their future occurrence, will determine the health and life of her offspring. Could the power for health conservation which exists in these visits of the medical attendant, be fully utilized, our infant mortality would be reduced as by no other means available.

This may seem a broad statement, but a review of the chief causes of our infant deaths indicates beyond all doubt that the one most common factor is parental ignorance; ignorance of the veriest fundamental principles of proper living; ignorance as to food, clothing, bathing; ignorance of proper ventilation, of the close relation of outside and above all indoor temperature to infant health; ignorance of decent cleanliness and, most deadly of all, ignorance of the ignorance that will be offered to her on every side

by friends and neighbors, as ill-prepared as herself to care for her baby. Here the family physician is given an opportunity which comes to no other set of men. So great and vital is this chance that it is doubtful if even the attention he gives to mother and child during the active stages of labor will equal it in life-saving. The most assiduous and skilled attention during an attack of gastro-enteritis will not atone for the unspoken warning against the improper preparation of that infant's food, which, given earlier in its life, might have prevented the illness. As a health educator no department, however highly organized, may vie with the family physician whose humanity leads him to employ his intellect and opportunities to the saving of infant life.

Official activity, however paternalistic in intent, is at best a stranger influence. It never obtains the confidence and trust that is spontaneously accorded the family doctor, nor may it hope to do so. It appeals to the intelligence of individuals alone while his words carry, aside from the weight of their wisdom, the appeal of a trusted friend. The health department may and should assist him in many ways. It is usually equipped to supplement his words of advice with printed instructions, demonstrations and trained visiting nurses, but its success will be measured largely by his support and interest.

It would be futile to attempt to touch upon the many aspects of this close and growing relationship of the family physician to the public health. In the lives of most of our people he is the first sanitarian and in those of many the only one. All material of statistical value, without which organized preventive medicine would be impossible, is derived directly through the family physician. He is the keystone of all sanitary achievement; the outpost of health civilization, of community protection and, as such, must inevitably assume an immense responsibility, not only to his patient, but to the family, community and state.

The medical association should consider itself an advisory board to the health department and should take the lead in the community in assisting in the suppression of customs and conditions prejudicial to the public health and welfare. It should give time and thought to securing health legislation, local and general; in exploiting the pernicious influence of charlatans as the venereal and cancer quacks, the consumption specialist, the institutions, found everywhere, for the quick cure of drug users, one of the most heartless of all financial schemes ever devised by the renegades of the medical profession. It should, through its members, ceaselessly warn unfortunate victims to drugs of the futility of spending their money for correspondence or home cures and, as a body, should advise and urge in their several communities the formation of health departments for the improvement of sanitary conditions.

The question of midwifery which, in the South especially, has a wide and vitiating effect on infant life, must be solved by the medical profession and the health departments of this state. In my own city the still-birth rate in the practice of these women is twice as high as in that of the medical profession, and their activity, through their ignorant methods and teachings, as agents of infant mortality is equalled, I believe, by no other single factor. This is a matter which, through needed legislation, must eventually be taken over by the general practitioner.

These and many other matters might be dealt with at length did time permit, but of one problem especially do I wish to speak before closing. Affecting, as it does the health of a large number of our people and bearing profoundly on their social and economic welfare, its control and regulation rests largely within the province of the medical profession, both as a body and as individuals. I refer to the widespread and rapidly increasing addictions to habit-forming drugs. It is a world-wide question as

has been shown in recent years by the calling of the International Opium Commission in Shanghai, in 1909, through the initiative of our government and of the International Opium Conference at The Hague in 1912. In each country, however, aside from governmental jurisdiction, it must receive the serious attention of states and cities and, in such, what body of men is better fitted by training and experience to cope with this enormous question than the medical profession? Not only does their better knowledge of the dire results of these addictions especially fit them for this service to humanity, but a peculiar and definite obligation is placed upon them in that, to no small degree, are they responsible for the conditions referred to.

The valuable medical properties of opium and its derivatives have occasioned its widespread use as a therapeutic agent and it is quite possible that its habit-forming nature was not fully appreciated in the earlier stages of medical learning. Such knowledge, however, has been available for a sufficient period, to have stimulated a more general professional interest and a greater degree of caution than is apparent at the present time. So well known and generally admitted is the role of the practicing physician as an etiological factor in drug addictions, that specific data are scarcely required at this time. I believe, however, that a brief report of our findings in Jacksonville may be of interest to this Association.

Through the operation of a city ordinance which has been in effect for nearly two years, a considerable amount of information has been secured, relating to the extent of these habits and the various factors entering into their formation. Aside from the usual provisions common to most "dope" laws, our ordinance provides that:

"(a) All druggists filling prescriptions for habit-forming drugs shall keep a record of all such prescriptions and that the originals shall be open to inspection by the police and health departments.

"(b) That every physician writing a prescription containing more than a specified amount of opium derivatives or cocaine, shall place thereon the name and address of the individual for whom it is intended and shall send a copy of the prescription to the health department.

"(c) That the health department may, if it be deemed expedient, furnish free to any habitual user, a prescription for the drug employed."

These three are the essential features of the law concerned with the collection of various information. Through this means we have been able to obtain a very accurate census of the users in the city, the drugs employed, and the amounts taken. We have likewise learned which physicians and druggists deal principally in this traffic and, through the last mentioned provision, I have come into personal touch with about 300 users and have been able to obtain from them information relating to the formation of their habits.

During the year 1913, there were recorded in my office 887 habitual drug users, 1.31 per cent of our total population. These were grouped by color and sex as follows:

Table 1.

	No.	Per cent.
White males	290	32.69
White females	328	36.98
Colored males	98	11.04
Colored females	171	19.28
Total males	388	43.74
Total females	499	56.26
Total whites	618	69.67
Total colored	269	30.33

It will be noted and is of interest that the women considerably outnumber the men and the whites the negroes. This is contrary to popular belief. A predilection for certain drugs and combination of drugs exists in both the races and sexes, as shown by the following table:

Table 2.

	Per cent of users.	White males.	White females.	Colored males.	Colored females.	Total.
Morphine* ...	32.92	94	142	20	36	292
Cocaine	39.00	102	109	58	77	346
Laudanum ...	12.18	23	30	11	44	108
Heroin	3.16	19	9	0	0	28
Gum opium...	1.58	4	4	3	3	14
Cocaine and opiate combined ..	11.16	48	34	6	11	99
Totals	100.00	290	328	98	171	887

From the histories obtained the following were given as direct causes of the formation of their habits:

Table 3.

From prescriptions of physicians	122 or 48.8%
Through dissipation	76 or 30.4%
On the advice of friends.....	47 or 18.8%
Owing to chronic and incurable disease	5 or 2.0%

As direct causes may be given:

First, the conditions, for the relief of which, the users sought a physician or accepted the advice of friends or acquaintances, frequently themselves users. These conditions, in 123 cases, are given below in the order of their frequency:

Rheumatism 27; pelvic inflammation 24; accidents 21; headaches 12; surgical operations 10; "stomach trouble" 7; other more or less prolonged illness as dysentery, typhoid fever, nervous disorders, nasal catarrh, asthma, etc., 22.

Second, the druggist who refills prescriptions containing opiates without consulting the physician writing them or who sells the drugs in question upon the request of the purchaser and without any prescription or order from a physician.

*Codeine is included under this heading.

Third, prostitution. Of the 887 users of whom I have record, 129 are shown by their addresses to be prostitutes. This does not include a considerable number who have no obvious occupation and whose addresses, close to the restricted districts, indicate, at least, close association with vice and immorality. The influence of prostitution is still further shown in the first group of contributory causes under rheumatism and pelvic inflammatory disease, where venereal infection was responsible in the majority of cases. Here we have a vicious circle of prostitution, venereal infection carried home with resulting drug habit and, not infrequently, another prostitute.

Besides the foregoing, ignorance, alcoholic excesses, evil companions, curiosity, and, above all, the facility with which these dangerous drugs may be obtained almost everywhere in the country are contributory causes of importance operating to create and perpetuate the drug user.

In obtaining these histories, I have made every effort to arrive at the truth and I believe that my findings are not far wrong. Some observers place a still greater percentage of drug users at the door of our profession, but the figures I have given are hideous enough to require no additions.

Leaving all discussion of exact figures aside, our knowledge, as medical men, of the insidious effect of these drugs upon the physical and mental beings and the well-known careless manner in which they are employed by certain practitioners is alone sufficient to convince us of the agency of these members of the profession in the formation of this army of unfortunates. We may not say that the user need not have continued to refill the prescription or, that after learning its pain-allaying ingredient, showed weakness in procuring it. Which one of us, ignorant of the dangers of anodynes, and acting on supposedly expert advice, might not be "weak" when seeking relief from pain? It must be remembered, too, that though raw opium became widely used in

certain countries through ignorance and viciousness, its alkaloids, far more powerful and deadly, were introduced and first used by the medical profession and have become national vices in countries where smoking opium was scarcely known.

Our knowledge of these drugs is such that every dose given should be regarded as a potential factor in habit formation and their promiscuous use abandoned accordingly. He who administers a hypodermic injection of morphia, or who prescribes codeia, heroin or other opium derivatives in tablet or other form to a neurasthenic woman with obscure pelvic pains, to the over-tired business man suffering from insomnia, to any patient afflicted with a temporary painful condition does so in full knowledge that at some future time these individuals, again finding themselves subject to painful affliction, will remember the relief obtained from the drug administered by the family physician, and, anxious to save the price of his professional visit, may seek at the drug store the active principal of his prescription. No one, at all familiar with the profound systemic impression made by opiates may deny that the suggestion produced by, and the recollection of, the action of these drugs opens an avenue of temptation that is difficult for the average individual to resist.

It may be truthfully said, I believe, that this view is coming to be more generally accepted by the medical profession of recent years. The harm that has already been done however, and that is still being done, even though in lessening degree, requires our best efforts to correct. This State is in need of a modern statute to handle the situation. Lay knowledge of these drugs is now such that their use is increasing with startling rapidity and among all classes of people. Legislation that aims to really control the situation must, it is generally conceded, take cognizance of the careless physician as well as of the manufacturer and druggist. Individually and as an Association the physi-

cians of the State can render invaluable service in securing the passage of such a law and it would appear to be their duty as the natural guardians of the public health, however much or little of responsibility we may care to admit.

ENEMAS, WISE AND OTHERWISE

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There is perhaps no single therapeutic procedure which yields more tangible comfort or relief than a properly administered enema. Like the stone which the builders rejected, but which became the head of the corner, the humble enema sometimes becomes the main reliance in times of bodily danger and pathologic stress.

While general information on this subject may be obtained from various textbooks, there are but few sources, in the knowledge of the writer, where specific information concerning enemas may be acquired, and for this reason a practical discussion of this useful subject may be profitable.

The various manners of injecting fluid into the bowel come under this term, though there are many variations in method and indication.

The principal methods consist of:

1. The simple enema, where fluid is injected into the lower bowel,
2. Irrigation with a single tube,
3. Irrigation with a double-current tube or other special appliance,
4. Proctoclysis by the drop method of injection.

There are quite a number of indications for the employment of enemas, among which may be mentioned:

Diseased conditions of the gut, such as catarrhal colitis, proctitis, or prostatitis, or any acute inflammation in the pelvic region. Enemas are further indicated for the relief of pain and irritability in the anal region, as

in spasm of the sphincter, to aid in the absorption of inflammatory products in the pelvis, as in post-uterine adhesions, to replace the loss of fluid in the body, as in cholera, or after severe hemorrhage, to dilute the poison of disease and promote diuresis, as in uremia, to check hemorrhage by the local effect of fluid either very cold or hot, as in hemorrhage from ulcers in the rectum, to assist in emptying the bowel, either by direct irrigation or by the presence of the fluid, to stimulate the gut to expulsive efforts, as in constipation or obstipation from retained masses of hardened feces, to affect the heat centers, as by hot irrigations in lowered temperature from shock, or cold irrigations in high fever, to exert an antispasmodic effect, as in colic, to aid in the expulsion of gas, as in excessive tympanites, to exert a mechanical effect, as in intussusception, to employ the fluid as a vehicle for the introduction of nourishment, as in the employment of nutritive enemata, and to act as a vehicle for parasiticide agents, as in the presence of intestinal parasites.

There are few mechanical measures in the realm of treatment of the sick that admit the display of more tact, ingenuity and skill than in the administration of enemas. To inject into the bowel a sufficiency of fluid to meet a given indication, without pain or discomfort to the patient, so that it can be retained long enough to accomplish the desired purpose, is not such an easy matter as one would suppose.

The necessary apparatus for enemas may consist of a one to a four-quart fountain syringe of rubber, or an irrigating jar of glass or porcelain with an opening at the bottom. To this is connected with rubber tubing nozzles of various sizes and shapes, or, the part for introduction into the bowel may consist of a simple glass tube, a tube with a recurrent flow, or a soft-rubber catheter.

Either hard-rubber or glass nozzles, or soft-rubber tubes are preferable for the injection of hot fluids, as the degree of heat a

metal nozzle reaches becomes uncomfortable to the patient.

The amount of hydrostatic pressure requires judgment. In irritable states of the intestinal mucosa, the flow should be slow and gentle, perhaps frequently interrupted, so that the sensitive bowel will not spasmodically contract. Under such conditions, the container need be only one or two feet above the buttocks, though ordinarily three to five feet is not too high. An elevation higher than that, unless extreme pressure is desired, as in intussusception, is fraught with danger.

Quantity. The amount of fluid to be injected depends upon the results desired. To simply stimulate lagging peristalsis, a pint or even less is usually sufficient. Many individuals are slightly inclined toward constipation, and need only a gentle stimulus to "awake," as it were, intestinal contractions. Many of these people have in the toilet a fountain syringe, which is brought into use, should the regular daily evacuation be tardy. The employment of a small enema of warm water under such circumstances causes practically no disturbance of the alimentary tract, and is greatly preferable to the constant and promiscuous self-administration of cathartics.

Enemas intended to flush the colon, or to dislodge fecal accumulations higher up, may consist of a quart and a half, or even two quarts, the latter being a maximum. The practice of introducing into the bowel vast quantities of water—one or two gallons, or even more—is reprehensible, and liable to cause dilatation, followed by paralysis of the intestinal muscles.

Let me insist that several enemas of one quart each are infinitely better than one enema of several quarts. If this paper convinces its readers of this one basic fact, my efforts will be well repaid.

Many times if the first enema is fruitless, the water returning clear, if repeated one or more times, peristalsis will be set up, the

hardened contents will in the meanwhile be softened, and satisfactory elimination will ensue. The mere fact of repeated injections need raise no more apprehensions than the mere fact of repeated ablutions to a soiled and crusted skin.

Temperature. Cold enemas are indicated only in the presence of hemorrhage or hyperpyrexia. Their use is limited and generally any benefit which might be attained by the injection of cold fluid into the bowel, is more comfortably and safely accomplished by other means. Generally speaking, the fluid should be about the body temperature, perhaps a little warmer. For the relief of inflammation in the intestinal mucosa or adjacent structures, the water may be quite hot. Though a higher temperature is advised by some authorities, I would hardly advise an irrigation with a temperature above 125 degrees Fahrenheit.

The irrigating tube must never be removed while the hot solution is in the rectum, as, should it come in contact with the anus, it would cause decided pain. Remembering that the interior of the rectum will comfortably bear a heat that the anus can not endure, the nozzle or tube should not be withdrawn until after the fluid ceases flowing, and then slowly.

Lubrication. Proper lubrication is conducive to comfort, and vaseline, olive oil, castor oil (warmed) or even toilet soap will answer. Laundry soap, or the cheaper grades of turpentine soap, while useful in the water, are unsuitable to lubricate a tube that passes over a tender or excoriated surface.

Preparation of the Irrigating Fluid. A simple enema for the gentle stimulation of peristalsis may consist of warm water alone.

The so-called S. S. enema consists of warm water into which sufficient soap is rubbed to form a liberal amount of soap-suds. In such an enema laundry or turpentine soap may be utilized, as these soaps exert a slightly stimulating effect.

The normal saline enema consists of a level teaspoonful of common salt to the pint of water.

An oxgall enema contains one teaspoonful of oxgall to the pint of water.

Various carminative enemas may be prepared by adding one or more tablespoonfuls of milk of asafetida or one teaspoonful of powdered alum or borax to the quart of water or a weak infusion of camomile may be used.

Emollient enemas contain cornstarch in sufficient quantity to thicken the fluid; or flaxseed meal or slippery elm bark, the solution being strained. Gum arabic or tragacanth is also used.

Antiseptic enemas may contain permanganate of potash one or two to five thousand, nitrate of silver fifteen grains to the quart, phenol thirty grains to the quart (be sure it is returned), commercial sulphuric acid, half a dram to the quart, or liquor alkaline antiseptic (N. F.) one or two ounces to the quart.

For softening and healing enemas there may be employed several of the oils. These are helpful in the treatment of constipation, and when rightly used are often successful. For healing an irritated intestinal mucosa there may be added to the oil a small amount of phenol, one dram to the pint, tincture of iodine, the same amount, or bismuth subnitrate in any quantity desired, provided the oil is not made too thick by its addition. For inflammatory conditions, when pain or tenesmus is present, and the oil is not to remain in the bowel for long, the amount injected may vary from eight ounces to a quart.

In constipation the method is different. Not over three ounces should be injected the first time, though, as the patient finds the bowel will contain more, this amount may be increased up to eight ounces. The oil should be slowly injected while the patient is on the left side, and if possible should be retained all night. This usually is practicable unless the rectum is very irritable or

the anus is patulous. The injection of oil is generally followed by a satisfactory evacuation the following morning, but in the event that it is not, a small water enema or glycerin suppository will usually set up intestinal contractions.

The Proper Oil. Some advocate pure olive oil, which is expensive and hard to obtain; linseed oil also has been recommended, but the best and most satisfactory oil in my experience is the cottonseed oil, especially after it has been refined for cooking purposes. The various cooking oils are cheap, easily obtained at the nearest grocery store, and answer every purpose accomplished by an expensive oil.

The Colon Tube. Let me say that in most instances this is fallacious, so far as any advantage of high injection. Experiments with opaque fluids under the roentgen ray have convinced the writer that the whole large intestine can be well filled from a tube extending just past the internal sphincters. The long and flexible colon tube generally coils up in the ampulla of the rectum, and is worse than useless. It should be relegated to the limbo of the obsolescent.

Irrigation of the Large Intestine. This is accomplished by several methods. To irrigate with a single tube, a colon tube or hard-rubber nozzle may be attached to a rubber tube about two feet long, which is surmounted by a funnel. The water is poured into the funnel, sent into the bowel from an elevation of about two feet, and siphoned out by suddenly lowering the funnel, as in gastric lavage. This method is not very satisfactory, and the best method lies in the several forms of recurrent tubes, in which the water flows out as fast as it enters. By this means an unlimited amount of the irrigating fluid may be introduced into the intestines, which besides mechanically cleaning them, results in the flatus being removed by the suction of the return flow.

I prefer the Kemp recurrent irrigator, or the Albright small hard-rubber irrigator. The principle is simple, consisting of a

double, rigid tube, the fluid entering by a central tube, while the outflow is carried off by the outer tube into which the fluid flows through the lateral orifices.

In using the double-current irrigating tube, the patient may be either on the back or side, just so the hips are elevated. The height of the irrigating jar should be from three to five feet above the patient. Allow the fluid to flow from the tube before insertion, so as to force out the air, check the flow, and renew it as the tip of the instrument passes well through the sphincters, forcing the mucosa away from the irrigator and lateral fenestrae. The tube should be inserted with a gentle rotary movement with the tip directed slightly back towards the sacrum. Should the flow cease, rotate the tube slightly, or gently withdraw it while rotating, and then gently push it backward and forward until the flow is resumed. Occasionally, when there is much hardened fecal matter present, the larger masses need to be cleared with a soapsuds enema, previously softening them with oil or glycerin. When withdrawing the recurrent tube, bring it out with a gentle rotary movement, to provide against the mucosa catching in the fenestrae.

Temperature of the Irrigating Fluid. This may vary from 100 degrees to 105 degrees F., in intestinal catarrh and to 110 degrees F., in typhoid fever or any toxic condition, as this higher temperature increases its eliminative effect.

Solutions Employed. Thin flaxseed tea, normal saline solution with spirits of peppermint, cinnamon, or fennel, plain water with milk of asafetida, soda, boric acid, potassium permanganate, or the alkaline antiseptic liquid previously mentioned may all be employed.

Another irrigating fluid I wish to specifically cite as worthy of use is the plain kerosene oil of commerce. Besides its amebicide effect, which I have discussed elsewhere, it yields excellent results in chronic proctitis and colitis, where there are old and

unhealthy ulcers, resulting perhaps in a chronic diarrhea. In such conditions an irrigation of one quart on alternate days, until three or four irrigations have been given, will in most cases afford gratifying results. There seems to be no danger of toxic effects, for in several instances quite a residue of the oil has been retained for one to three hours before escaping, and in no instance under my observation has any evil or disquieting symptom ensued.

Proctoclysis. By this is meant the injection of normal saline or other solution into the rectum by the drop method, as first suggested by Murphy. This procedure is of value in sepsis, and is a useful adjunct to other treatment in post-operative shock, intestinal dilatation and atony, and uremia. The technic can be found in all recent works on surgery.

In conclusion let me urge the importance of thoughtful care of the large intestine, and the intelligent use of the humble but useful enema.

922 Candler Building.

CONSERVATIVE ABDOMINAL CESARIAN SECTION.*

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Jacksonville, Fla.

What I have to say will not, I am confident, meet with the approval of the entire medical profession. What is said is not intended as a criticism of the profession or any member thereof, what I record being my personal observation of certain conditions met with in my obstetrical practice, therefore you will not be overburdened with scientific matter.

The history of this operation dates back to the days of the early Egyptians and was done as a routine on women dying in childbirth, the operation is also referred to in the myths of the early European races. Dionysus was cut from the dead Semele.

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

The operation on the living was also practiced in the early days. Felkin, as early as the fifteenth century, records the natives of Uganda as having performed the operation after preparing the patient and their hands with wine made from the banana. The patient was made drunk with wine and made a quick recovery.

In 1500, J. Nufer, a swine gilder of Switzerland, successfully delivered his wife in this way after a dozen midwives and several barbers had failed to deliver by the birth canal. Although this operation was undertaken on the living in the early ages, it was never done unless it was clear that the woman would surely die and that the child might be saved. Kayser reports a mortality of 82 per cent in 1844. Tarnier states there was not a successful case in Paris up to his time during the nineteenth century.

The cause of death in the early operations was due to either hemorrhage or infection. Until Sanger, in 1882, introduced the first suture into the uterus during the operation, it is no wonder that a great number died. In 1887 Parro advised the removal of the uterus to prevent infection. In our present day of surgical technique we need not stand back on these grounds.

Since the early nineties the obstetricians have looked to the field of surgery to aid them in obtaining better results and today surgical principles are applied to obstetrics but are often neglected or badly abused. Physicians have been too slow in many cases in resorting to surgery or to call in one who will carry out the proper surgical treatment necessary to save the life of mother and child. Not every case of obstetrics with complications calls for abdominal Cesarean section but there are a great many cases which demand this operation in which the prospective mother is denied the benefits of surgical interference until it is clear to the surgical thinking obstetrician that it is too late to benefit either her or the child. No man trained in our profession would allow

a patient under his care to slowly die of intestinal obstruction, whether the patient be man, woman or child, nor would he stand by and see a woman slowly bleed to death from a sub-mucous fibroid, or from an ectopic gestation. A man with stricture of the penis or rectum can readily get relief but how many women and unborn children go to the Great Beyond because we as a profession do not grasp the one great idea that obstetrics is a surgical condition and that it should be so treated. Until a few years ago the students of our medical schools were taught to look to the welfare of the mother in this most trying ordeal and to give the unborn child but secondary consideration, not hesitating to kill or mutilate it if by so doing the mother's life might be saved, disregarding the fact that she might thereafter be an invalid for life with her pelvic organs in such condition as to be a burden to her.

The right thinking man will agree that from the beginning of conception until parturition there are two lives entrusted to the physician's care and it should be his duty and required of him that he take the proper steps necessary to save both lives. He should not follow a procedure which, while it may save the mother, will leave her an invalid for life nor should the child be subjected to a line of treatment which in all probability will leave it in a badly disfigured condition or worse, one who will grow up mentally deficient. No doubt there are many today behind prison bars, and others that help fill our various reform schools and asylums, who if the truth were known, are there as a result of pressure producing hemorrhage in the undeveloped brain from the use of forceps. Such a hemorrhage may be small, giving no symptoms immediately after birth but in later years when the area of the brain in which the hemorrhage is located is called upon to perform its functions the effects of hemorrhage at birth become evident.

Indications for Abdominal Cesarean Section.

It is generally recognized that every woman should place herself under the care

of a physician just as soon as she becomes pregnant and that the physician should leave no stone unturned in caring for her and the prospective child. He should fully instruct his patient concerning her personal care and the effect of this care upon the physical development of the child. He should look closely to the eliminating organs, constipation should be relieved, by the use of drugs, the urine should be examined every few weeks, and at frequent intervals should the slightest trace of albumen be discovered. Toxemia is to be dreaded in all cases. A woman may be suffering from a well marked toxemia and yet not show albumen in her urine, so when she presents clinical symptoms indicating a toxic condition, the nitrogen output should be determined and proper steps taken to rid the patient of toxins before they result in eclampsia, for this is the most dreaded of all toxemias and is one of the greatest indications for conservative Cesarean section. There are more theories advanced on the etiology of eclampsia than we could well discuss in a week; in my opinion it is due to a defect in metabolism. When the patient's condition is fully known by the physician and he has been prompt in his eliminative treatment but without beneficial results, it is not then wise to wait for the appearance of convulsions before instituting radical treatment. In all severe toxemias the uterus should be emptied as quickly as possible, adopting the least dangerous method, having in view the saving of both mother and child. We should not lose valuable time with dilating bags, by forcible dilating and tearing a rigid cervix with instruments or hand, nor wait until the patient is exhausted as a result of her efforts to give birth to the child. We should not use opium or some other narcotic and feel that we have done our duty, or kill the unborn child by a mutilating operation or by unsuccessful attempts to deliver through the birth canal, but should at once advise a Cesarean section which would, in all probability, save both

mother and child, making invalids out of neither but preserving them both in a normal physical and mental state. We can deliver in one half the time with about an equal amount of preparation, the maternal mortality in palliative and slow delivery is, according to the best authorities, from 20 to 45 per cent, the infant mortality from 30 to 60 per cent. In rapid delivery the maternal mortality is reduced from 2 to 15 per cent and the infant mortality from 2 to 10 per cent. The more rapid the delivery after the first convulsion, the lower the mortality for both. In the presence of eclampsia, I have had four cases in which I did Cesarean section without the loss of either mother or child.

Under palliative and slow delivery I have had 8 cases, losing one mother and three infants. In the case in which the mother was lost the infant was still-born, both would probably have been saved by a more rapid delivery but the husband would not give his consent to an operation.

A positive indication for Cesarean section is where the size of the child is out of all proportion to the pelvic outlet, making a normal delivery impossible. The narrowing of the pelvic outlet due to the presence of tumors or an exostosis of the pelvic bones also calls for this operative procedure.

Placenta previa centralis is another indication for Cesarean section and in these cases even when the patient has lost considerable blood the operation is well stood and but little additional hemorrhage need occur.

Contracted pelves as an indication for this operation is considered by most authorities under two heads; absolute and relative. An absolute indication being when there is no other way of delivering either a living or a dead child. Relative indication is where a mutilated or dead child can be delivered through the birth canal.

To enable one to be ready for this complication when labor sets in, a physician should use the pelvimeter in his routine examination of all pregnant women for this instrument is just as important in the care

of the pregnant as the thermometer is in the care of a fever patient or the X ray in the treatment of fractures. According to most authorities when the conjugata vera measures less than 6 or $6\frac{1}{2}$ c. m., Cæsarian section is absolutely indicated. With a measurement of over $6\frac{1}{2}$ or 9 c. m., the condition is a relative indication for operation, it is my opinion that both of these are absolute indications for a conservative Cæsarian section. What has been said in reference to the surgical treatment of eclamptic cases is also true in cases of this class. We should not wait until the patient has exhausted herself in labor or until we have exhausted her through unsuccessful attempts to deliver her and then expect the operation to be of any value, for under these circumstances the operation is more than apt to be brought into disrepute. Under these etiologic factors I have had 4 cases without the loss of either mother or child. One patient had had a very difficult labor five years previous in New York, an instrumental delivery resulting in the loss of her child and causing the birth canal to be so badly lacerated that the vagina and cervix uteri were a mass of scar tissue which would not yield to uterine contractions. She had been in labor for 24 hours before Cæsarian section was accomplished. Two of the cases had to submit to surgical procedure owing to contracted pelves complicated by large infants. The fourth case was one of placenta previa centralis.

Among other complications that we meet with in obstetrical practice calling for Cæsarian section may be mentioned abnormal presentations while in cases in which there exists a persistent posterior occiput with a head wedged in the pelves and unable to rotate, Cæsarian section offers the most probable manner for the successful delivery of the infant with a minimum danger to the mother.

Contraindications for Conservative Cæsarian Section.

In cases where the patient is exhausted

from her own efforts and where we have no proper hospital facilities to maintain a proper technique.

In cases where the woman is in labor with a dilated cervix or where the cervix is pliable and there is no disproportion between the child and the pelvic outlet. An abdominal section should not be attempted where the child is dead or in cases which have been frequently examined or undergone manual manipulation.

It is my belief that in a short time with proper surgical principles together with careful analysis of individual cases applying to obstetrics, we will read of destructive and mutilating operations as a thing of the past.

The use of high forceps on a head that is not engaged should be condemned.

A careful obstetrician can in almost every case determine his line of treatment before the patient goes in labor, he can have all of his preliminary preparations made, such as posting the family what to expect and assuring the patient that he will care for her without difficulty. Hospital arrangements should be made. There is no woman who wishes to become a mother that would not gladly go through an operation of Cæsarian section for a perfect living child, rather than go through an instrumental delivery or mutilating operation, for a dead or a mentally deficient one, and be herself a sufferer and invalid.

General Observations.

As we have said under the head of Eclampsia and Obstruction, the most important contraindications are, when the life of the patient is about exhausted and when the patient has been examined frequently by questionable hands. In any obstetrical condition, as in any other abdominal surgical condition, this operation should not be undertaken except under proper surgical surroundings, and by a man of experience in abdominal surgery, together with competent assistants. This procedure, being a child, as well as maternal, saving operation, should not be done if the child is dead,

unless the difficulties of delivery are seen to be insurmountable by the birth canal.

The Technic of Cesarean Section.

This can be found in all works on obstetrics and varies only in minor details. There are a few differing points, such as the location of the incision in the uterus, which is a matter of choice with the operator.

The amount of blood lost can easily be controlled. In toxic cases it is well to let the patient bleed freely, allowing a greater loss of blood than in other conditions. The patient is then given normal saline solution in proportion to the amount of blood lost. The uterus before being closed should be packed with gauze saturated with three per cent iodine solution. After closure by a double row of sutures, preferably plain catgut for the muscle, and chromic catgut for the sero muscular sutures, the abdomen should be closed in layers. The operator should then see if there is proper dilatation of the cervix, thereby assuring good drainage. The gauze packing in the uterus can be removed at this time or twelve to twenty-four hours later. It is well to have the patient's stomach washed out on the table before she awakens, leaving a suitable dose of castor oil or sulphate of magnesia in the stomach. This will clear the alimentary tract within twelve hours, lessening, especially in toxic cases, the discomfort and the danger of acute dilatation of the stomach. After the bowels have moved well the patient should be placed on a liquid diet for twenty-four hours and then gradually the diet may be increased. The baby should nurse regularly after the first twenty-four hours. In all of these cases it is my practice to give, from fifteen to twenty drops of the Fluid Extract of Ergot t. i. d., to aid involution. The patient should be kept in bed for at least ten days.

The question of sterilizing the patient during the operation is an important one, and should not be thought of except in cases where some chronic disease is present.

The influence of Cesarean section on future pregnancies is very slight when the uterus is properly closed and is not followed by an infection. One of my patients has had a normal labor without any complications since her operation. She was operated on the first time for eclampsia, two more of my patients are now pregnant, one of whom, in all probability, on account of a contracted pelvis will have to undergo the operation a second time.

VINCENT'S ANGINA; WITH REPORT OF A CASE.*

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Some time in March our cook failed to report for duty on a Monday morning, but sent a substitute who said that the other woman was very sick with a sore throat. I called during the forenoon and found the patient in bed complaining of a very sore throat and fever.

Her temperature was 101.4 F., she had a heavily coated tongue, a fetid breath and had a thick grey membrane on the right tonsil. I swabbed the tonsil, inoculated some blood serum and made smears from the swab. In the smear I found some irregular staining bacilli resembling the diphtheria bacillus and, believing from the clinical symptoms that I was dealing with a case of diphtheria, I did not wait for the culture but gave 10,000 units of antitoxin early in the afternoon and quarantined the patient.

The next morning when I examined the culture I found only staphylococci and streptococci. In talking with Doctor Henry Hanson regarding the case he suggested Vincent's Angina. I immediately made some more swabs stained with carbolfuchsin and found the bacillus fusiformis and a long spirilla.

*Read before the Duval County Medical Society, June, 1914.

The antitoxin had not affected the condition at all though the membrane had not spread.

As I knew that Doctor Manning was treating some cases of Vincent's Angina I asked his advice in the matter of treatment and, at his suggestion, used a local application of silver nitrate solution, 100 grs. to the ounce. After two applications a day for three days, the membrane cleared up, the soreness disappeared and the patient was feeling well by the end of the week.

On account of the lack of information in regard to this condition in most of the text books I decided to look up the literature on the subject and as it is very frequently confused with diphtheria I thought the subject might be of interest to the Society.

Vincent's Angina, known also as Ulceromembranous angina and stomatitis, Pharyngitis ulcerosa, Angina diphtheroides, Angina chancreforme and Spirochätenbacillen angina, may be defined as a faucial lesion, usually unilateral, characterized by membrane formation, ulceration of tonsil and adjacent structures, a peculiar fetid odor, enlargement of corresponding lymph glands and associated with a fusiform bacillus and a long spirillum.

Etiology.

Age. Majority of cases reported were from 18 to 25 years of age, though Athanasiu reports a series of cases with ages varying from 26 months to 13 years.

Sex. Males most affected.

Predisposing Causes.

Tobacco, trauma of mucous membranes; eruption of wisdom teeth; defective teeth; scurvy; syphilis; acute infections, such as measles and scarlet fever, chronic enlarged tonsils and adenoids.

Bacteriology.

According to Tarassawicz, Rauchfus was first to note the association of the fusiform bacillus and spirilla with disease processes. In 1893 he presented cases of ulceromembranous angina in which he demonstrated

pointed bacilli and spirillae and his photographs show them to be identical with those described by later writers. Plant, in 1894, described the fusiform bacillus and large spirilla in cases of hospital gangrene. Bernheim, in 1897, reported 30 cases, and in 1898 Vincent reported 14 cases of ulceromembranous angina, in all of which the fusiform bacilli and spirillae were present.

Following this, French, German, English and American observers have reported cases, showing the widespread occurrence of the disease.

The infrequency with which the disease is recognized is probably due to lack of direct examination of the exudate, and the fact that the organisms do not grow on ordinary media.

The organisms may occur with the diphtheria bacillus, in syphilitic lesions of the mouth and throat, and has been found on tonsils and between teeth in healthy mouths.

The description of the organisms, according to Tunncliffe and Weaver, is as follows:

Bacilli; long slender rods with pointed ends, larger in the middle, may be bent or S shaped 6 to 12 microns long, 6-10 microns wide, usually scattered uniformly over the field; may occur end to end or grouped like diphtheria bacilli. They stain with Loeffler's methylene blue, anilin gentian violet, best with carbol-fuchsin or Giemsa's stain, and are Gram negative.

The spirilla, the so-called *Spirachaeta denticola*, are long and delicate and present three or four turns, are motile, stain faintly and are Gram negative.

These organisms are supposed to act in symbiosis. The disease is milder when only the bacilli are present. The spirillae are always present where there is deep destruction of tissue. These organisms are obligate anaerobes and can be grown on ascitic agar under anaerobic conditions.

Pathology.

The disease can be divided into three periods though these can not always be differentiated:

- (1) Onset, characterized by congestion and edema,
- (2) Formation of pseudo membrane,
- (3) Ulceration and necrosis.

Location.

The lesion is usually located on the tonsil and edge of gums. It may extend to uvula, tongue, lips, soft palate, pharyngeal wall and cheek although extension is not common.

The ulcer is usually circular or oval and in most cases is unilateral. It seldom spreads but may become deeper. It has a punched out appearance, like a syphilitic ulcer, with an uneven floor which shows granulating points.

The pseudo membrane may be grey, white, yellow, yellowish brown or greenish in color and is usually friable, though it may be tenacious and resemble the pseudo-membrane of diphtheria. When the membrane is removed it leaves bleeding points and usually reforms in a few hours.

The submaxillary or retromaxillary glands are enlarged according to the location of the disease. The glands are firm and there is usually no periadenitis or suppuration.

Healing takes place in from three to four days although the glandular enlargement may persist for a longer period.

A case of mastoiditis due to the fusiform bacillus and spirilli is reported in the Journal A. M. A., July 10, 1910, Yates.¹ A girl, twelve years of age, with a neglected running ear of several months' standing developed mastoid swelling with rather high temperature. On operation, very foul smelling pus was found which contained the organisms of Vincent's Angina. The patient left the hospital and was not heard from until a month later when she returned to the hospital with a discharging sinus back of the ear, which had opened after an attack of measles. After two weeks' ineffectual treatment the ear was treated with a pure culture of lactic acid bacillus and after two treatments at two days' intervals the sinus closed and complete recovery followed.

The organisms probably do not affect the ear primarily, but as a secondary infection are very difficult to get rid of. Held² reports a case of mastoiditis with a pure culture of Vincent's organisms where death resulted from a purulent meningitis.

At the Laboratory of the N. Y. Eye & Ear Infirmary the organisms are frequently seen in pus from middle ear disease, mastoid, and old brain abscesses but always in mixed culture.

Symptoms.

The symptoms may be none or slight and the lesion found accidentally but the usual symptoms are dryness and discomfort in the throat, dysphagia, lassitude, restlessness at night, loss of appetite, headache, coated tongue, chills and fever. The fever is usually slight, average temperature being about 101 degrees F., though it may go nearly to 104 degrees F. One to five days after the onset the local condition is observed. The chief symptoms are dysphagia, fetid breath, salivation. If the gums are affected the teeth may be loose. In children nasal discharge may be the first symptom.

Complications.

Tunnick and Weaver report as complications; albuminuria, herpes, gastro-enteritis and noma.

Niclot and Marotte report also as complications appendicitis, pseudo-rheumatism, arthritis, endocarditis, pleurisy and purpura.

Prevalence.

The disease is quite prevalent, although many cases are not detected.

Rolleston gives a report of 3,876 cases of angina in the Grove Hospital from 1905 to 1909, 610 of which were non-diphtheritic.

He found that 9-10 per cent of all cases of angina and 4.9-10 per cent of all non-diphtheritic angina were Vincent's angina.

Vincent found that 2.2 per cent of all cases of angina were due to the fusiform bacillus and spirillus, but his cases were soldiers between the ages of twenty and twenty-five years.

Contagion.

Contagion has been observed by Vincent and others, but close contact is necessary. Pipes, pencils, purse-string tobacco bags have been suggested as means of spreading the disease. Small epidemics may occur in families.

Diagnosis.

Examine exudate direct. Exclude diphtheria by culture and syphilis by history of case. Always look for organisms of Vincent's Angina in a unilateral pseudo-membranous angina.

The prognosis is good, although there may be considerable destruction of tissue. Gangrene and noma may develop and the disease may recur.

Treatment.

Potassium chlorate internally is considered a specific. Local applications of tincture of iodine or of silver nitrate are advised. I secured good results with a 20 per cent solution of silver nitrate. Hydrogen Peroxide is recommended, either alone or as used by Tunnicliff and Weaver in their series where they followed the use of Hydrogen Peroxide by applications of the following solution:

Carbolic Acid 5ss.

Zinc sulpho carbolate 5ii.

Aqua q. s. ad 3ii.

Powdered methelene blue has been used successfully to heal up the ulcers.

Local applications of strong silver nitrate solution, combined with use of Potassium chlorate internally, is probably the most satisfactory treatment.

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PROSTATIC HYPERTROPHY*

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The large number of old men who spend the winters in Florida, many of them afterwards making it their permanent home, make this subject particularly interesting to us who have to treat them.

I shall take up, in a brief way, my method of operation with the post-operative treatment, claiming nothing original, but showing a large percentage of recoveries.

The following symptoms, according to Freyer, are indications for operation:

1. There may be from three to fifteen ounces of residual urine, and the patient not using a catheter.

2. Extreme overdistention and dribbling.

3. Retention from time to time.

4. Ability to void some urine, although the patient is obliged to use a catheter to obtain rest and comfort.

5. Entire dependence on the catheter.

6. Complete retention.

We are using the cystoscope in making our differential diagnoses and follow the usual anti-operative treatment; Urotropin for several days before, pushing the fluids, withdrawing residual urine, either by putting in permanent catheter or catheterizing frequently; two ounces of castor oil forty-eight hours before operation, cleansing the skin with benzine solution, and painting with 3½ per cent Iodine at time of operation.

In our series of twenty-three cases, we used the perineal operation, the "Y" shaped incision, in twenty-one cases, and the combined operation, perineal and supra-pubic, in two. We lost three cases, all dying from uremia, one eighty-four years old, this case being complicated with a stone as large as a hen's egg, and a small contracted pusy bladder; one eighty years old, a case of

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

carcinoma, with retention; and one sixty-seven years old, a case of distended bladder, with the bladder walls containing many abscesses. These three cases were really emergency operations, but bring up our percentage of deaths.

We are using Young's technique, which is familiar to all of you, on account of the shorter period of convalescence; although we differ as to the length of time we keep our patients in bed, believing that getting them out on the second day is too early, their condition being a better guide. We follow no routine but are guided in the matter by existing conditions. Most operators today, I believe, are taking this ground and not allowing their patients up too early.

In the combined operation we use Fuller's technique, which is not a difficult one after once using it. The bladder is opened suprapubically, making a small incision in the median line perineally on a guide, if possible, passing a long grooved director up behind the sphincter vesicae, and using a long knife which enters the bladder splitting the prostate; a finger is placed in the perineal opening and with a finger in the bladder enucleation is accomplished rapidly, the entire operation, taking only about fifteen minutes. Drainage tubes are inserted perineally and suprapubically. This, I consider, the best combined operation, especially in old pussy bladder cases which require dependent drainage. The perineal tube is removed in three days and the suprapubic tube in five days. The simple suprapubic operation is the operation of choice for an operator with short fingers, as he can readily enucleate with one finger in the rectum, pushing the prostate upward with one finger in the bladder. I think the operation should be selected for the patient, and not the patient for the operation.

Prostatectomy is not an easy operation, as the subjects are old and do not tolerate long continued anaesthesia with safety, which necessitates the operator working with great rapidity. If a surgeon keeps his

patient under an anaesthetic for two hours or more, and does not attend to the necessary details before or after operation, his mortality rate will be high, but with the necessary treatment before, the proper operation selected, and rapidly done, and with the careful after-treatment, the relief afforded these elderly men certainly repays us for our time and trouble.

PROPAGANDA FOR REFORM.

ASSIMILATION OF CALCIUM PHOSPHATE.—Extensive experiments have demonstrated the availability of calcium phosphate for the bone formation of growing infants. This is a further proof of the power of the human organism to utilize inorganic substances. (*Jour. A. M. A.*, Aug. 15, 1914, p. 581.)

ADMINISTRATION OF FRUIT ACIDS.—The administration of the salts of the ordinary fruit acids is useful whenever it is desired to increase the alkalinity of the blood and diminish the acidity of the urine. Important investigations indicate, however, that it is scarcely feasible to produce any very marked effect on the alkalinity of the blood in this manner. If the physician believes that the alkalinity of the blood is an important factor in the recovery from gout and rheumatism, the administration of the salts of fruit acids is appropriate. Citrates should be preferred to tartrates, for the latter are imperfectly converted to carbonates and, when given in large quantities, may cause irritation of the kidneys. (*Jour. A. M. A.*, Aug. 1, 1914, p. 420.)

HECTINE.—Hectine, referred to in newspapers as a treatment for hay-fever, is a French proprietary, stated to have a composition similar to that of atoxyl. If its composition is in accordance with the claims its action probably is no better than that of atoxyl. Arsenic is used in the treatment of hay-fever with success in some cases. (*Jour. A. M. A.*, Aug. 8, 1914, p. 502.)

MIXED VACCINE AND PHYLACOGENS.—The unscientific character of mixed vaccines

and of the mixed filtered products of a number of vaccines marketed as "Phylacogens" has been especially emphasized and the danger from their indiscriminate use pointed out. Recently John F. Anderson held that the claim that the combination of dead bodies or the filtered products of a number of different bacteria are useful for the treatment of certain diseases with a specific cause, closely approaches quackery. Victor C. Vaughan also has pointed out the danger of the indiscriminate use of bacterial products and observed that untoward results are rarely reported. Physicians who are tempted by the optimistic statements of manufacturers to give complex bacterial products a trial, should remember that the warnings of disinterested scientists are of far more value than uncritical clinical reports put out under commercial auspices. (*Jour. A. M. A.*, Aug. 29, 1914, p. 785.)

SEVETOL.—There was a time when physiologists thought that fats were absorbed into the blood in the form of a fine emulsion. It is now known that fat enters the blood after having been split into glycerol and fatty acid, the latter being, to a large extent, combined with alkalies in the form of soaps. Making use of the discarded theory Sevetol, put out by John Wyeth and Brother is presented to the profession with the claim that it is a very fine emulsion of fat and because of this is readily absorbed. While Wyeth and Brother would have physicians believe that Sevetol is readily absorbed and digested, it is evident that the amount of Sevetol which can be taken is limited not only by the power of assimilation but also by the power of digestion. (*Jour. A. M. A.*, July 4, 1914, p. 49.)

SODIUM FLUORIDE.—While the poisonous character of fluorides is recognized, the use of sodium fluoride as a food preservative is still considered. As a result of experiments, F. Schwyzer concludes that fluorine preparations are poisonous even when administered in very small doses. (*Jour. A. M. A.*, July 25, 1914, p. 323.)

STRYCHNIN AND CAFFEIN IN CARDIOVASCULAR DISTURBANCES.—Aided by a grant from the Council on Pharmacy and Chemistry, Dr. L. H. Newburgh has made a painstaking study of the action of strychnin and caffein on cardiovascular disturbances. He concludes that, since the blood-pressure is not low either in persons showing grave symptoms of pneumonia or of those dying from that disease, and since it has been proved that the vasomotor arcs are normal in animals after death from pneumonia, it is logical to conclude that the vasomotor mechanism is not impaired in pneumonia. Strychnin does not improve or augment the work of the heart in persons suffering from broken cardiac compensation. It could not be shown that either strychnin or caffein stimulated the cardiovascular apparatus in any of the conditions studied. (*Jour. A. M. A.*, July 25, 1914, p. 311.)

TOXICITY OF CAMPHOR.—A case is reported in which an 18-month-old child was given after a meal, a teaspoonful of camphorated oil (linimentum camphorae) by mistake. While this dose must have contained about 15 grains of camphor, no untoward symptoms were observed. (*Jour. A. M. A.*, Aug. 15, 1914, p. 579.)

WINE OF CARDUI.—While the Chattanooga Medicine Company asserts that in the manufacture of Wine of Cardui no more alcohol is used than is necessary to preserve it, experiments indicated that the preparation contains only water-soluble constituents and that a non-alcoholic preparation might easily be prepared. Also, despite the owner's assertion that Wine of Cardui cannot be used as a tippie, large doses were taken experimentally with no observable effects other than those of alcohol; further, letters from physicians assert that the preparation is used habitually, evidently for its alcohol effects—probably unconsciously. The exploitation of Wine of Cardui is vicious and the public should be apprised of the facts. (*Jour. A. M. A.*, July 18, 1914, p. 258.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville.
Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association,
334 St. James Building, Jacksonville, Fla., U. S. A.

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ties: Y. E. Wright, M. D., Wauchula. 1916

Eleventh District—Dade, Monroe and Palm Beach
Counties: W. R. Warren, M. D., Key West. 1917

Next Meeting—DeLand—May 12-14, 1915

THE SOUTHERN MEDICAL ASSOCIATION.

The eighth annual session of the Southern Medical Association will open on November 9th, at Richmond, Va., under the presidency of Dr. Stewart McGuire and will remain in session until November 12th. From all indications this meeting is going to surpass in every detail each of its predecessors. The growth of the Association is and has been a steady and a healthy one and that it fills a needed want is evidenced by the rapidly increasing membership. Florida is well represented in the organization and many of her prominent physicians are actively connected with the affairs of the Association. We urge those who are not already enrolled to attend the Richmond meeting and to actively identify themselves.

The program includes public addresses by ex-Governor R. M. Cunningham, of Alabama, and Dr. Harvey W. Wiley, of pure food fame. The Oration on Medicine will be delivered by Dr. W. S. Thayer, of Baltimore; the Oration on Surgery by Dr. John A. Wyeth, of New York, and the Oration on Public Health by Surgeon-General Rupert Blue, of the United States Public Health Service. Dr. W. L. Rodman, of Philadelphia, president-elect of the American Medical Association, and Surgeon-General W. C. Gorgas, of the United States Army, will also take part in the program.

It is not hard to prophesy, therefore, that a scientific treat is in store for all in attendance. That the entertainment feature will not be neglected is assured by the fact that Virginia is the hostess. Alumni reunions and dinners are to be one of the entertainment features.

Special trains are being arranged for from the principal cities of the South and the railroads are offering attractive rates. Let Florida have a full representation.

THE SOUTHERN HEALTH EXHIBITION AND AMERICAN PUBLIC HEALTH ASSOCIATION MEETING.

Of much interest to this State at the present time is the coming meeting of the American Public Health Association which will be held at Jacksonville, November 30 to December 5. This convention will bring to the State representatives of health organizations of this country, Canada, Mexico and Cuba, and on its program will be found the names of the foremost sanitarians of North America.

Extensive preparations have been made for the entertainment of the guests, but of especial import to this State and, indeed, to the whole South, will be the Southern Health Exhibition which will continue from November 27 to December 6. Plans for this exhibition have been under way since the last meeting of the Association, which was held in Colorado Springs a year ago when Jacksonville landed the convention after a close race with Philadelphia.

Material has been secured from nearly every southern health agency, with the view of presenting to the members of the Association and the public at large, the essentially southern health problems and their methods of control. Practically every branch of sanitary science will be covered and many new exhibits will be shown.

Every town and city in the State should send a representative to this meeting and exhibition and it is safe to assume that ample profit will be derived from its attendance. This youngest branch of medical science, disease prevention, has made wonderful progress during the past decade and those who have not kept pace with its advances, both medical men and laymen, will find much of absorbing interest in this exhibition.

The latest work on typhoid, hookworm and pellagra, three of the greatest health problems of the South, will be represented, and general rural sanitation, race mortality,

child welfare, midwifery, milk and water supply, waste disposal as well as a host of other subjects bearing upon community health will be attractively demonstrated by special exhibits. A splendid opportunity will be given sanitarians to compare the merits of various methods and to the laymen present to learn to what ends health appropriations are being expended.

The Florida Medical Association as well as the city of Jacksonville invited this convention and the profession throughout the State should take a keen interest in its coming and its significance to our people.

In the November JOURNAL will be outlined the scientific program as now being arranged for the forty-second annual meeting at Jacksonville.

FROM OUR CONTEMPORARIES.

We are glad to add to our list of exchanges and this State Society Medical Journal that of the Florida Medical Association. Its first two numbers indicate that it will be a live progressive Journal.—*The Journal of the Medical Society of New Jersey*.

The Florida State Medical Association is the latest medical organization to enter the field of medical journalism. The first issue of their official Journal is a very creditable one.—*The Journal of the Oklahoma State Medical Association*.

We acknowledge receipt of Vol. 1, No. 1, of the Journal of the Florida Medical Association. Its reading matter, arrangement and general appearance promises to make it a welcome addition to our exchange list.—*Arizona Medical Journal*.

Florida has a State Journal with Dr. Graham E. Henson, of Jacksonville, as editor. The initial number made its appearance under date of July 18th and it is creditable to the editor and to the association. The size and style of the Journal are becomingly modest, double column reading matter, with clear text, with white cover and simple display of title and matter.

The editor of the Journal is well known among southern investigators in scientific medicine, particularly in malaria, and his discernment is here noted in his selection of his collaborators, who may be named as prominent in Florida medical circles—Drs. R. H. McGinnis, A. H. Freeman, Raymond C. Turck, Thomas Truelsen, G. R. Holden, James D. Love, J. L. Kirby-Smith and Henry Hanson.

The Florida Medical Association is to be congratulated upon its undertaking and upon its choice of editor. We extend our best wishes for a long and successful future and for the need of usefulness which such a beginning should augur.—*New Orleans Medical and Surgical Journal.*

The Florida State Medical Association has established a medical Journal owned and published by the association. The first number contains thirty-two pages of reading matter and sixteen pages of advertising, the latter censored and in harmony with the rules of the Council on Pharmacy and Chemistry. The new journal presents a very creditable appearance and will undoubtedly further the purposes of organized medicine in Florida. We welcome this publication to the list of journals owned and controlled by the State medical associations.—*The Journal of the Missouri State Medical Association.*

THE PLAGUE IN NEW ORLEANS.

The following report for the week ending September 28th, of Assistant Surgeon General W. C. Rucker, in charge of the operations for the control and eradication of bubonic plague at New Orleans, shows the extensive work that is being carried on to rid the city of this infection. The success in keeping down the number of human cases to twenty-eight, demonstrates the effectiveness of the methods being pursued:

Outgoing Quarantine.

Number of vessels fumigated with sulphur	70
Number of vessels fumigated with carbon monoxide	13

Pounds of sulphur burned.....	8,274
Coke consumed in carbon monoxide fumigation (pounds)	38,200
Outgoing freight inspected (tons).....	8,030
Total packages freight inspected.....	128,853
Clean bills of health issued.....	29
Foul bills of health issued.....	3

Overland Freight Inspection.

Cars inspected	3,758
Cars rat-proofed	2,074
Cars condemned	32
Rodents killed in cars.....	0

Destination of railroad cars inspected week ended September 26:

Alabama	123	Missouri	94
California	65	Nevada .....	...
Colorado	4	New Mexico	2
Dakota, South....	11	Oklahoma	14
Georgia	57	Rhode Island .....	...
Indiana	43	Utah .....	...
Kentucky	34	West Virginia....	3
Massachusetts ...	10	Wyoming .....	...
Mississippi	449	Arkansas	47
Nebraska	1	Carolina, South....	17
New Jersey.....	...	Dakota, North....	7
Ohio	58	Florida	51
Pennsylvania	12	Illinois	509
Texas	249	Kansas	15
Virginia	5	Maryland	4
Wisconsin	12	Minnesota	10
Canada	3	Montana	2
Arizona	4	New Hampshire...	...
Carolina, North...	16	New York	4
Connecticut	3	Oregon .....	...
Delaware	6	Tennessee	102
Idaho .....	...	Vermont .....	...
Iowa	21	Washington	3
Louisiana	1,304	District of	...
Michigan	27	Columbia	1

Field Operations.

Number of rats trapped.....	8,399
Premises fumigated	12
Premises disinfected	210
Premises inspected	6,876
Poisons placed	332,335
Notices served	3,906
Buildings rat-proofed during week ended September 26	199
Buildings rat-proofed to date.....	1,300
Number of abatements week ended September 26	1,357
Number of abatements to date.....	7,556
Number of dead inspected.....	116

Laboratory Operations.

Rats examined	5,776
Mus Norvegicus	5,593
Mus Alexandrinus	124
Mus Rattus	53
Mus Musculi	2,383
Unclassified, putrid	194
Total rodents received at laboratory...	8,347
Number of suspicious rats	16
Plague rats confirmed	35

Plague rats, viz:

Case No.	Address.	Captured.	Diagnosis Confirmed.	Treatment of Premises.
129—1017	Common St...	% ₂₀	% ₂₀	See Case 100.
131 and 132—160	S. Ram-part St.	% ₂₀	% ₂₀	See Case 101.
133 and 134—160	S. Ram-part St.	% ₂₂	% ₂₂	See Case 101.
135—2815	Dumaine St..	% ₁₆	% ₂₃	Summary de- struction rat harborage; rat- proofing initiat- ed; disinfect- ion; intensive trapping and poisoning.
136—Elevator "D"	Stuy. Docks	% ₂₃	% ₂₃	Disinfection; rat-proofing ini- tiated.
137—Trapped in sewer, corner Rampart and Common Sts.		% ₂₄	% ₂₄	Intensive trap- ping and poison- ing.
138—Girod Street Wharf.		% ₂₄	% ₂₄	Intensive trap- ping and poison- ing.
139—2009	Spain St.....	% ₁₈	% ₂₅	Intensive trap- ping and poison- ing.
140—1013	Magazine St.	% ₂₆	% ₂₅	Fumigation; summary de- struction of rat harborage; rat- proofing initiat- ed; disinfection.
142 to 147 inc. }	1013 Magazine St..	% ₂₆	% ₂₆	See Case 140.
148—2904	Melpomene St.	% ₂₆	% ₂₆	Summary de- struction of rat harborage; rat- proofing initiat- ed; trapping and poisoning.
149 to 162 inc. }	1013 Magazine St..	% ₂₆	% ₂₆	See Case 140.

These rodents were taken as result of summary destruction of rat harborage.

Suspicious human cases examined.....	1
Number of human plague cases.....	3
Total number of human cases to date.....	28

Human plague cases, viz:

Human Case No.	Name and Place of Infection.	Date Suspicious.	Diagnosis Confirmed.	Treatment of Premises.
26—	Clemence Alexand- er, 824 Burgundy St.	% ₂₁	% ₂₂	Fumigation; in- tensive trapping and poisoning.
27—	John J. Vath, 1463 Bourbon St.	% ₂₁	% ₂₂	Fumigation; rat- proofing initiat- ed; intensive trapping and poisoning.
28—	Mrs. Helen Schuler, 910 Elysian Fields.	% ₂₂	% ₂₃	Fumigation; rat- proofing initiat- ed; intensive trapping and poisoning.
Total rodents captured to September 26...				96,794
Total rodents examined to September 26...				86,639
Rodent cases to September 26 by species:				
Mus Rattus				6
Mus Alexandrinus				3
Mus Norvegicus				153

Total rodent cases to September 26... 162

THE ASSOCIATION OF ERYTHEMA NODOSUM AND TUBERCULOSIS.—On the basis of the tuberculin test (von Pirquet), applied in forty-eight cases of erythema nodosum in children from 2 to 13 years of age, all of whom gave intense positive reaction, Pollak states that the disease occurs in childhood exclusively in individuals infected with tuberculosis, and is in all probability a tuberculosis dermatosis. Three of these children later developed an active tuberculosis in the cervical lymphglands, meninges and pleura, while several had a history of antecedent tuberculosis of glands and bone. Five attempts at experimental inoculation (with blood and excised nodule from two cases, and a nodule alone from another), gave a negative result.—O. H. Forster, M. D., in *The Journal of the American Medical Association*.

THE COUNTRY PHYSICIAN AND CONGENITAL CLUBFOOT.—The country doctor, master of emergencies, controller of conditions, is dismayed at the infant with the clubfoot. The foot, now cartilaginous, soft, plastic, will grow harder day by day. He is between the devil of an undertaking to which he feels he can not do justice and the deep, cold sea of letting the days of opportunity slip neglected away. And it is not always in the early days only that the foot must be treated at home. A case must sometimes be carried through a long course of treatment to a successful finish or remain a perpetual discredit in the community. As a matter of fact, the cure if commenced early and conducted according to a few simple working principles, is much easier than it looks.—John C. Schapps, M. D., F. A. C. S., in the *Medical Record*.

Obituary

JOHN CLAUDIUS L'ENGLE, M. D., of Jacksonville

Dr. J. Claudius L'Engle died at Jacksonville, Fla., on September 9th. Doctor L'Engle was born in Jacksonville October 22d, 1840, and spent his entire life in the city of his birth. He was the second son of Capt. John Claudius L'Engle and Mrs. Susan Facio L'Engle. Early in his life he was engaged in railroad construction work in this city, being associated with his father and his brother, the late Mr. F. F. L'Engle. He later attended the Charleston Medical College, receiving the degree of Doctor of Medicine from that institution in 1862. Dr. L'Engle served with distinction as a surgeon in the Confederate army during the Civil war and saw service in many campaigns. He had charge of one of the largest hospitals in Florida and when peace was declared was mustered out of the service as surgeon with the rank of major.

Dr. L'Engle practiced his profession for a few years following the war but later became engaged in the drug business, with the late Dr. W. M. Bostwick as associate. This business was continued until the fire of 1901.

During the yellow fever epidemic of 1888 Dr. L'Engle took an active part in the campaign to stamp out this infection from the city of Jacksonville and the surrounding community. He served as a member of the executive committee of the Jacksonville Auxiliary Sanitary Association and as chairman of this committee of sanitation

did much toward the relief of the people during the ordeal that the citizens of Jacksonville passed through in that period.

In 1888 Dr. L'Engle became interested in the banking business which had previously been established by his two brothers, the late Capt. Edward N. L'Engle and Harry A. L'Engle, under the firm name of the State Bank of Florida. After the death of Capt. L'Engle in 1891, Dr. L'Engle succeeded his brother as president of this bank and held this office at the time of his death.

During the time of the fire in 1901, Dr. L'Engle served as chairman of the Board of Public Works, and was active in the relief work following this catastrophe.

He served as a member of the lower house of the State legislature in 1899 and was again elected in 1901. In 1910 he again returned to the legislature, serving as senator from the 18th district, which district he served during the sessions of 1911 and 1913.

Dr. L'Engle, as chairman of the Board of Trustees of the Daniel Memorial Orphanage and Home for the Friendless, was for many years active in the interests of this institution. With the interest of the institution at heart, he was a tireless worker and did much towards its maintenance and support. He also served as a member of the Board of Trustees of St. Luke's Hospital for a number of years.

Reviews from Current Literature

WAR SURGERY.

Behan, R. J., *Modern War Surgery*. Surgery, Gynecology and Obstetrics, Vol. XIX, 1914, p. 199.

Behan writes most interestingly regarding his experience in a Servian base hospital during the second Balkan war. It is worthy of note that the use of tincture of iodine is now almost universal in all armies. Fresh wounds are covered in the field without being washed or touched by fingers or instruments, with dry sterile first aid dressings, usually by the men themselves or by their uninjured fellows. Whenever possible the field surgeons or sanitary troops paint wounds and surrounding areas with tincture of iodine and apply dressings as indicated. The object of the sanitary personnel in the field is to stop fatal hemorrhage, apply sterile dressings, transport the wounded with as great ease as possible, especially those with wounds of abdomen or chest, to the field hospital, and to apply temporary splints to fractured limbs. No operating is done in the field and but little operating is done in the field hospitals, the object being to disturb the wounds and the patients as little as possible and get them to the fully equipped base hospital at the earliest possible moment. At the base hospital, if the wounds are clean, they are simply painted with iodine and fresh dressings are applied; if wounds are septic, a 2 per cent. iodine or 60 per cent. alcohol dressing is applied.

The writer in a footnote states that "It was fortunate indeed that the parts had not been cleansed with water, for it was to this non-interference that most of our good results were ascribed."

The writer comments on the relative infrequency of severe wounds from small calibre steel bullets at long range; often penetrating wounds of lung, abdomen and brain were healed promptly without interference. Bullets at close range, shell and shrapnel produced all the lacerated wounds.

The writer emphasizes the necessity for non-interference with wounds, except under most favorable aseptic conditions. He states that "The most important factors having influence upon the ultimate course of a wound are the primary dressing and the transportation."

[The lessons taught by military surgeons as to keeping fingers, probes, unsterile instruments, lotions, water, unclean bandages, etc., away from fresh wounds may well be applied to civil practice, particularly in cases of compound fracture, where primary non-interference and the application of simple sterile dressings is so essential to the prevention of infection. In contradistinction to most military wounds, immediate operation in gunshot wounds of the abdomen in civil life is almost always indicated because in the latter case the bullet is usually fired at close range when the full explosive or lacerating effect is exhibited, hence intestinal perforations are more apt to be large, numerous and lacerated.—R. C. T.]

DePage, Prof. Dr. Antoine, of Brussels, *War Surgery*, Address of the President of the International Society of Surgery. *Annals of Surgery*, August, 1914, Vol. LX, p. 137.

The writer states that the surgery of war owes much to America. Almost the first systematic and organized care of the wounded originated with the military surgeons and in the sanitary commission during the Civil war. The work done at that time, while crude, inefficient, and in many ways wrong and actually harmful, from the modern viewpoint, yet afforded a splendid foundation for future improvement.

The writer states "The time has passed when the art of war was but a manifestation of personal courage; the art of war has called science to its help, and the response has been a fearful perfecting of the means of destruction. * * * With us rests the task of developing the organization of our war surgery so that it may remain on a level with the sad needs of our times."

"The Balkan war has only emphasized the lesson taught by the Manchurian war; the fate of the wounded depends more than all on the aid which is given in the front of the battle, for as long as the engagement lasts, the exposed ground is inaccessible for the ambulance men, of whom more than one has sacrificed his life in spite of all precautions taken. * * * The following is without doubt the solution: Each of the combatants must carry with him, side by side with his cartridges, the objects necessary for a first aid dressing. This solution has already been accepted and taken into use in different countries; * * * but the experience of the late wars has only proved too clearly that, before all, the sanitary education of the soldier must be improved. * * * He must fully realize the dangers of infection by earth, dust and water; of what use is a disinfected compress if it is soaked in polluted water?"

"The military instruction of a soldier in future will not be complete unless it comprises an acquaintance with the necessary measures to take for his personal safety, and especially the elementary rules of asepsis and antisepsis."

The writer states that while it is true that immediate help at the front is the most efficacious, yet it must be limited to precautionary measures. The dressing stations and other temporary hospitals on the first line are only stopping places where the wounded are sorted out. "Unfortunately they are not always made use of in this way; during the Balkan war the Turkish army surgeons and others tried to extract bullets and amputate in the ambulance at the front and we were able to certify that on the arrival of the wounded at the hospitals of the town, the greater part of these interventions had produced deep-seated suppurations."

Prof. DePage enters a strong protest against the use of shrapnel, because of their horrible efficacy, and expresses the wish

that they be abolished on the same grounds as explosive bullets.

In view of the recent horrifying events in Belgium, the closing paragraph of Prof. DePage's address strikes with added force and pathos. It is perhaps prophetic:

"It seems to me that here, so far away from the lands divided by a deadly animosity, you will appreciate this as a protestation against that cruelty of war. Yes, I boldly state, that we who are brought into close contact with the dreadful miseries of this poor human race, find it more and more difficult to understand, why men do not employ their reasoning powers to a good end by ceasing this destruction of one another. We hope soon to see the 'United States of Europe' in friendly intercourse with the 'United States of America'."

MILITARY FIRST AID IN MILITARY SURGERY.

Garcia, L. C., Capt. M. C., U. S. Army, *The Practical Application of Military First Aid in Railway Surgery*. J. A. M. A., January 31, 1914, Vol. LXII, p. 372.

Garcia describes the wreck of a troop train in which 17 men were killed and 160 injured. The emergency work was done in the military manner by the hospital corps men most intelligently and efficiently.

There were over ninety open wounds, incised, lacerated or punctured. All wounds were simply painted with tincture of iodine and the military first-aid dressing applied.

There was one infection; that of a compound fracture of the tibia and fibula, where the man had been pinned under the wreckage for six hours in such position that an occlusive dressing could not be applied.

IODINE IN SURGERY.

Wilder, W. H., *Iodine Technic in Surgery*. Southern Medical Journal, August, 1914, Vol. VII, p. 655.

Wilder discusses the current use of iodine in elective and emergency surgery. He uses the two solutions—No. 1, of one part iodine crystals to 1,000 parts of benzine, and No. 2, of equal parts 95 per cent grain alcohol and

freshly prepared U. S. P. tincture of iodine. The solutions are kept in the office and hospital and are carried in the emergency grip.

In contused or lacerated wounds, no soap or water is used, but they are cleansed of all dirt and grease by applying solution No. 1 with sterile gauze held in sterile forceps. After drying, solution No. 2 is applied in like manner and the wound covered by a simple sterile dressing. "This dressing is allowed to remain about 48 hours, and generally when removed the wound is found to be clean, and usually heals without pus."

The skin must be dry before the solutions are applied. If shaving is necessary, it should be done dry, or with alcohol, benzine or ether.

In compound fractures, solution No. 1 is applied freely, first to the outside, then to the inside of the wound. After drying, solution No. 2 is applied. No fingers should come in contact with the wound, the solutions are applied with sterile gauze on sterile forceps, and only loose pieces of bone are removed with sterile instruments. The limb is then put up, preferably in a plaster cast, through which dressing windows are cut.

In elective surgery, Wilder has the field shaved and a bichloride dressing applied the evening before operation. In the operating room the two solutions are applied after the skin has been dried.

[The overnight application of mercuric iodide, instead of bichloride dressing, seems preferable in that the iodide is less irritating, does not coagulate albuminous substances and, theoretically at least, harmonizes with the application of the tincture of iodine. In the operating room the skin is dried with ether, then painted with the iodine-benzine solution, then with 3½ per cent tincture of iodine, and the excess of iodine wiped away with alcohol. This method seems particularly efficacious and thus far there have been no infections following it.—R. C. T.]

POLYPOID CHONDRO-FIBROMA.

Outerbridge, George W., Polypoid Chondro-fibroma of the Fallopian Tube, Associated with Tubal Pregnancy. *Am. Jour. Obst.*, August, 1914, Vol. LXX, p. 173.

Outerbridge remarks on the infrequency of new growths in the Fallopian tubes. He reports a case of a tube removed on account of an early pregnancy in which a small, papillary growth was found filling the lumen just proximal to the site of the extrauterine pregnancy.

Microscopic examination showed the tumor to be a degenerated fibroma, covered on the surface by tubal epithelium, and containing areas of hemorrhage, blood vessels, fatty degeneration and hyaline cartilage. Although no connection between the tumor and the tube wall was demonstrated, it had undoubtedly existed in the shape of a small pedicle.

The growth was essentially a fibroma with an area of cartilaginous metaplasia, and not an embryonic mixed tumor.

It seems very probable that this tumor which almost completely blocked the lumen of the tube near the uterine end may have caused the arrest of the ovum and the subsequent development of the extrauterine pregnancy.

THE NINHYDRIN REACTION.

Berman, Louis, The Application of the Ninhydrin Reaction to the Urines and Urine Dialysates of Pregnant Women. *Am. Jour. Obst.*, August, 1914, Vol. LXX, p. 192.

Berman reviews the Abderhalden test for pregnancy and Warfield's method of applying the Ninhydrin reaction to the urine of pregnant women. He does not agree with the theoretical foundation of Warfield's work and questions the value of his method as a diagnosis of pregnancy.

In order to test the value of the method he performed the reaction with the urines of 155 persons. Ninety-seven were the urines of pregnant women, 48 were those of non-pregnant women, and 10 were urines of men. His results led to the following conclusions:

1. The dialysates of the urines of pregnant women very often react positively to ninhydrin and sometimes negatively.

2. The dialysates of non-pregnant women very often react positively to ninhydrin and sometimes negatively.

3. The dialysates of the urines of normal men very often react positively to ninhydrin and sometimes negatively.

4. The reaction to ninhydrin of urine can not be relied on as a test of pregnancy.

TYPHOID FEVER IN CHILDREN.

Chapin, Henry Dwight, A Clinical Study of Typhoid Fever in Children. *Am. Journal Diseases of Children*, August, 1914, Vol. VIII, p. 130.

Chapin takes the ground that, contrary to the generally accepted opinion, typhoid fever is about as prevalent among children under twelve as among adults. The routine employment of Widal's test shows that undoubtedly many cases of typhoid of a mild or unusual type have been overlooked and incorrectly diagnosed. In a series of cases he reports attention is called to some important differences in the symptomatology of the disease as it exists in children and adults. Rose spots are found with comparative rarity in children and in the cases reported by Chapin there was an absence of the leucopenia that is supposed to accompany typhoid fever. The author advocates a generous diet in the affection, believing that such is necessary to maintain the vitality and resisting power of the patient and that the danger of relapses is thereby lessened. The eleven cases reported occurred in children under eight years of age and were allowed the general ward diet with the exception of meat. This consisted of milk, cocoa, eggs, bread, toast, crackers, cereals, jelly, potatoes, gravy, broths, custard, junket, apple sauce, orange juice, ice-cream and lady fingers. They received nourishment every three hours during the day. The effort to feed them forty calories per kilo per day was not quite successful, since children, unlike adults can not be forced to take food.

Out of eleven cases reported there was an actual gain in weight in seven instances, a very slight loss in two and an appreciable loss in two others. There were no severe complications and no relapses.

EPINEPHRIN IN URTICARIA.

Swann, A. W., Acute Urticaria Treated With Epinephrin, *American Journal of Medical Sciences*, March, 1913, Vol. CXLV.

Swann reports a series of cases of acute urticaria and serum rashes successfully treated with subcutaneous injection of 1-1000 adrenal solution; the dose administered being eight minims for a patient of one hundred and forty pounds.

He found that two doses administered at intervals of ten minutes always produced desired results, improvement being manifest in from seven to ten minutes. The author suggests that this agent be employed in a similar but more serious condition, angioneurotic oedema affecting the larynx and epiglottis. There is a possibility that the bronchial spasm accompanying anaphylaxis may be relieved by this agent.

THE SHICK REACTION.

Park, Wm. H.; Zingher, Abraham, and Serota, H. M., The Shick Reaction and Its Practical Applications. *Archives of Pediatrics*, July, 1914, Vol. XXXI, p. 481.

It has been demonstrated that only those individuals contract diphtheria who have no antitoxin or an insufficient amount in their blood or tissues. To estimate the existence of immunizing antitoxin in the blood and thus to separate the susceptible from the non-susceptible individual is rendered possible and practicable by the application of the Shick test.

The reaction depends on the local irritant action of minute quantities of diphtheria toxin when injected intracutaneously.

If immunizing antitoxin is present in the blood no appreciable reaction occurs at the site of injection. If little or no protective antitoxin exists in the blood, then as a result of the injection and at its site there is observed within from twenty-four to forty-eight hours a circumscribed area of redness

and slight infiltration constituting a positive reaction.

Absence of antitoxin from the blood gives a positive reaction, its presence a negative reaction. The essentials for the test are a standard diphtheria toxin, properly diluted with normal saline, and a hypodermic syringe with a small needle.

The site selected for the injection is immaterial as concerns the reliability of the test, but since a positive reaction leads to a more or less persistent brownish pigmentation, cosmetic reasons would suggest the selection of a part of the body where blemishes are least objectionable. The positive reaction persists from seven to ten days.

The more positive and intense the reaction the less antitoxin in the blood. (In this respect this is directly contrary to the cutaneous tuberculin test.) The reliability of this test was proven by tests made on 700 children in the Willard Parker Hospital of New York. Of the patients here tested, 57 per cent gave negative reactions, and while these patients were thereafter exposed to the possibility of contagion none received artificial antitoxin immunization and none developed diphtheria, though about one quarter of this number became bacillus carriers. It was assumed that the 300 patients who responded positively to the Shick test were susceptible to diphtheria, and therefore practically all received some artificial immunization. In spite of this, however, 42 developed diphtheria. The Shick test is of marked practical value in that it enables the physician to distinguish between the susceptible and non-susceptible individual; to say after an exposure to infection which individual needs immunization by an antitoxin injection and which one requires no artificial protection. (For obvious reasons the needless administration of antitoxin for immunizing purposes is to be deplored.)

The application of the test assists the physician in differentiating clinical diphtheria from diphtheria carriers.

It demonstrates the efficiency of immunizing and curative antitoxin medication and has added further proof that intravenous and intramuscular injections of antitoxin are more prompt in result and more efficient than subcutaneous injections.

DIAGNOSTIC METHODS IN SYPHILIS.

Fordyce, J. A., *Modern Diagnostic Methods in Syphilis*. New York Medical Journal, September 26, 1914, Vol. C, p. 597.

In a review of modern diagnostic measures Fordyce calls our attention to the fact that the Serologists are at variance in the reports of the Wasserman reaction, and the value of the test is in accordance with the training of skilled laboratory workers. Attention is called to the value of careful clinical training in recognizing the various stages of the disease, this with the microscopical demonstration of the spirochaeta pallida in the suspected lesion, the reaction of the blood to the Wasserman test, the findings in the spinal fluid, and the cutaneous, or luetin reaction, constitute our modern diagnostic measures in syphilis.

TREATMENT OF CONGENITAL NEW GROWTHS OF THE SKIN AND MUCUS MEMBRANE.

Clarke, William L., *The Dessication Treatment of Congenital New Growths of the Skin and Mucus Membrane*. Journal of the A. M. A., September, 1914, Vol. LXIII, p. 925.

The author brought before the attention of the section on Dermatology of the A. M. A., at the recent meeting at Atlantic City, the results of his experience for the past six years in treating new growths of the skin and mucus membrane with a high frequency current generated from a special static machine on the order of fulguration. By his method the treatment was practically painless, and the amount of disruction of tissue was under the control of the operator, the author claiming good result in the treatment of neoplasms of the skin.

VERRUCOSE DERMATITIS.

Hazen, H. H., Verrucose Dermatitis. Southern Medical Journal, September, 1914, Vol. VII, p. 710.

In an article with two illustrations and the report of six cases, Hazen calls our attention to a very interesting skin condition, which he claims is not so uncommon as the writers of texts claim. Of the six cases in the report four are in the negro, one in a white man, while the race of one is not given. Mention is made that Dermatitis Vegetans is an advanced stage of Verrucose Dermatitis. The author recommends surgical treatment for the condition, thorough currettement under general anesthesia, and cauterization with actual cautery or the acid nitrate of mercury.

SECOND INFECTION WITH SPIROCHÆTA PALLIDA.

Corbus, B. C., A Second Infection with Spirochaeta Pallida. New York Medical Journal, September 5, 1914, Vol. C, p. 472.

Corbus reports a second infection with the Spirochaeta Pallida, the patient developing the second infection one year and eleven months after the last negative Wasserman.

DIPHTHERIA OF THE SKIN OF UNUSUAL TYPE.

Knowles, F. C., and Frescoln, L. D., Diphtheria of the Skin of Unusual Type. Report of Two Cases. Journal of the A. M. A., August 1, 1914, Vol. LXIII, p. 398.

These authors report two unusual cases of diphtheria of the skin, both of the bullous impetigo type; one of the cases terminated fatally. Attention is called to the fact that diphtheritic skin lesions are a constant source of contagion because they are frequently unrecognized for a considerable period; they may last over a long period or run a rapidly fatal course.

BROMODERMA OF THE LEG.

Weiss, Ludwig, An Unusual Case of Bromoderma of the Leg. Journal of the A. M. A., August 22, 1914, Vol. LXIII, p. 635.

Weiss reports an unusual case of Bromoderma of the leg, giving three illustrations.

The lesions had been in existence for several years, and offered considerable difficulty in the diagnosis. Among the diseases considered were: tuberculosis, syphilis and blastomycosis. The final diagnosis was made by a process of elimination. The following conclusions were given:

1. Drug eruptions may simulate almost any known skin affection.
2. A skin eruption starting suddenly without any prodromal symptoms is almost sure to be a medicinal eruption.
3. The violence of development, the preponderance of the local over the systemic disturbances is characteristic of drug eruptions.
4. The brevity of the acute stage and the quickness of defervescence constitute a notable asset in diagnosis.
5. The usual four stages of the acute contagious exanthems, namely, the prodromal stage, the eruptive, the fully developed and retrogressive and desquamative stage are wanting.
6. The temperature never rises to a point shown by the acute exanthems, and the affection of the mucous membrane is never so severe.

DYSIDROSIS.

Gottheil, Wm. S., Dysidrosis, Progressive Medicine, September 1, 1914, Vol. 16, p. 119.

Gottheil calls attention to dysidrosis as a common skin condition but usually diagnosed as eczema, and somewhat difficult to cure, recurrences being frequent. Dysidrosis being an affection of the sweat glands, occurs almost always in those locations where the sweat glands are most numerous and best developed, on the palms and soles and in the clefts of the fingers and toes. Attention is called to the examination of the margin of lesions for the characteristic clear vesicles. The following formula is recommended: Ammoniated mercury, ten parts; carbolic acid, half part; thymol, half part; menthol, one part; glycerine, two parts; wool fat, benzoated lard and lime water of each to make one hundred parts.

COMPLEMENT-FIXATION IN GONORRHOEA.

Kolmer, John A., and Brown, Claude P. Complement-Fixation in *Gonococcus* Infections. *The Journal of Infectious Diseases*, July, 1914, Vol. XV, p. 20.

The authors of the above article conclude that "About sixty per cent of all cases of gonococcus infections reacted positively in the gonococcus complement-fixation test. In the few cases of pyosalpingitis examined, sixty-six per cent reacted positively. The highest percentage of positive reactions, eighty-three per cent, occurred in cases of arthritis, considered clinically as possible gonococcus infections.

"The gonococcus complement-fixation test is of particular value in aiding the diagnosis of the nature of an obscure arthritis, in pelvic inflammatory diseases of women, to deciding whether or not a given case of urethral infection is cured or still harbors foci of living gonococci and aiding in the diagnosis and management of vaginitis in female children.

"The reactions are not generally as satisfactory as those occurring in the syphilis reaction because the quantity of gonococcus antibody is much smaller unless grave and widespread gonococcus metastases exist, and the fixation of complement by bacterial amboceptor and antigen is not so marked as that occurring with syphilis reagin and a lipoidal extract.

"In a comparative study of a number of sera tested with both the antishoop and anti-human hemolytic systems slightly better results were secured with the latter.

"To be of any value gonococcus antigens must be polyvalent. An antigen composed of a simple suspension of organisms in saline solution yielded eleven per cent better reactions than filtrates. It appears that the bacterial protein, aside from the endotoxins, aids in the antigenic effect. Alcoholic extracts of gonococci possess little or no value.

"The occurrence of positive reactions in about nine per cent of cases of chronic

gonococcus infections with antigens of staphylococci, streptococci and diphtheroid bacilli, indicates the active role these organisms may assume in these infections. The occurrence of about five per cent positive reactions with an antigen of the micrococcus catarrhalis would indicate that this organism may be likewise active in chronic urethritis.

"A study of antigonococcus and anti-meningococcus sera with antigens of gonococci and meningococci, indicates the close biological relationship of the gonococcus and meningococcus, and while their respective amboceptors are most specific for their own antigens, in lower dilutions this specificity is not so apparent and the results constitute another example of 'group' reaction similar to those occurring with the group of streptococci, diphtheria bacilli, spirochetes, etc."

AN ATTEMPT TO TRANSMIT POLIOMYELITIS.

Francis, Edward. An Attempt to Transmit Poliomyelitis by the Bite of *Lyperosia Irritans*. *The Journal of Infectious Diseases*, July, 1914, Vol. XV, p. 1.

On account of successful experimental transmission of poliomyelitis from monkey to monkey by means of the biting fly, *Stomoxys calcitrans*, Francis has attempted similar experiments by using the *Lyperosia Irritans*. Experiments were conducted in the United States Marine Hospital at Savannah, Ga., in August and September, 1913.

"*Lyperosia Irritans* is a blood-sucking fly found in great numbers on cattle. Its most striking gross characteristic is the head-downward position which it assumes on a cow."

The flies were allowed to feed on monkeys sick with poliomyelitis and later allowed to bite rhesus monkeys for a varying period of from three to eight days. The experiment, however, failed to show that poliomyelitis was transmitted in this manner.

NEWS ITEMS.

Dr. Sheldon Stringer, City Physician, Tampa, has returned from his summer vacation spent partly recuperating, and partly working on surgical problems in eastern hospitals. During his absence his position with the city of Tampa was filled by Dr. George A. Lassman.

Dr. Stanley Erwin, of Jacksonville, spent the last two weeks of September touring in his car through North Carolina.

Dr. G. E. Dawson, of Wauchula, spent a week very pleasantly among Tampa friends. A part of his vacation he spent recuperating at Green Springs.

Dr. H. M. Taylor returned to Jacksonville on the 15th after an absence of several weeks spent in the eastern cities and at the Mayo Clinic at Rochester, Minn.

Dr. Raymond C. Turck returned to Jacksonville after spending a month in New York and Chicago.

Dr. C. W. Bartlett, Tampa, has returned from New Orleans where he was sent by the State Board of Health to study the plague situation. Since his return he has repeatedly urged upon the city authorities needed sanitary reforms.

Dr. W. E. Ross, of Jacksonville, returned the first of October after several weeks' spent in Vermont, his old home.

Dr. Ralph Duffy, formerly of Plant City, has located in Tampa. He is limiting his practice to surgery.

Dr. G. R. Holden, of Jacksonville, returned home after having spent the summer in the mountains of North Carolina.

Dr. Henry Hanson, Senior Bacteriologist of the State Board of Health, recently spent a couple of weeks in New Orleans studying the methods used for the control of bubonic plague.

Dr. W. J. Lancaster, Tampa, after spending his vacation in New York, has returned. He has severed his connection with Drs. Helms and Rowlett and opened up an independent suite of offices in the Citizens' National Bank Building.

Dr. Robert L. May has removed from Jacksonville to Quitman, Ga.

Dr. W. A. Claxton, of the State Board of Health, has returned home after spending several weeks at Tampa.

Dr. John E. Boyd returned to Jacksonville the first of October, after spending several weeks in the cities of the east.

The first regular monthly meeting of the Duval County Medical Society was held in Jacksonville on the evening of the 6th inst. A number of matters of interest to the profession were brought up for discussion and papers were read by Dr. Henry Hanson and Dr. J. Knox Simpson. A complete report of the transactions will appear in the next number of the JOURNAL.

NEW AND NON-OFFICIAL REMEDIES.

LACTOBACILLINE SUSPENSION.—A pure culture in tubes of the *Bacillus bulgaricus* grown in a neutralized bouillon medium. This culture tends to inhibit the growth of deodorant, putrefactive and pathogenic organisms and is used externally in various suppurative conditions. Marketed as Lactobacilline Suspension, containing 5 cc., and Lactobacilline Suspension, Surgical, containing 20 cc., in each tube. Franco-American Ferment Co., New York. (*Jour. A. M. A.*, June 13, 1914, p. 1891.)

UREASE-DUNNING.—A highly potent and standardized preparation of the ureolytic enzyme obtained from the soy bean. It decomposes urea into ammonia and carbon dioxid. It is used for the determination of urea in urine, the amount of ammonium carbonate, formed from the ammonia and carbon dioxid produced is determined by titration with volumetric acid. Urease-Dunning is supplied only in the form of Urease-Dunning Tablets, containing 0.025 Gm. Hynson, Westcott & Co., Baltimore, Md. (*Jour. A. M. A.*, July 11, 1914, p. 165.)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

St. Augustine and Jacksonville, Florida, November, 1914

Number 5

ORIGINAL ARTICLES

SURGICAL AND CONSERVATIVE TREATMENT OF JOINT TUBER- CULOSIS.*

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The object of this paper is to give a survey of the various operative and non-operative methods used in the treatment of joint tuberculosis at the present time. The field covered is very large; the opinions encountered very diverse and conflicting. Very few generalities are in place, but as such I would say that our treatment today is more conservative than fifteen years ago, that joint tuberculosis in children is quite a different thing as to prognosis and treatment from joint tuberculosis in adults, and that proper hygienic care of the patient, that is, fresh air, good food, and rest, are more important than any one measure of treatment, operative or non-operative.

I shall first discuss non-operative methods of treatment.

Tuberculin.

The profession is much divided on the efficiency of tuberculin in surgical tuberculosis. Many are for it; many are against it. Long ago Virchow and Orth claimed that tuberculin caused a dissemination of the process, an objection that Koch vigorously combatted.

It is pretty generally agreed that its use in small doses (not over 1-1000 mg.) and in the right class of patients is not attended by ill effects. Febrile cases are not suited to the treatment. The average time between injections is ten days. The opsonic

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

claimed at present that this treatment is to index should be determined frequently. Swenson, of Chicago, says that 1-1000 mg. every ten days is a working rule he has followed for a number of years. One observer advises to use the Von Pirquet test. If this is strongly positive it is to be assumed that tuberculin is not necessary, that the reaction of the body is already sufficient.

As to the tuberculin to be used, Murphy uses "old tuberculin." Many use Rosenbach's tuberculin. It may be injected under the skin of the chest or into the joint, and the febrile reaction should not exceed 99.6° F. (Murphy).

In this country Murphy, Ochsner, Packard, and Swenson are some of the writers who have had good results in joint tuberculosis. Abroad—Wilms, Rosenbach, Raw, and de Quervain extol its value. But, the general opinion of these writers is that it is to be regarded as adjuvant to surgical treatment. They claim that tuberculin given over long periods ($\frac{1}{2}$ to 2 years) will cure joint tuberculosis in its incipency, but advanced tuberculosis must be removed with the knife before instituting the treatment. Other writers as Lovett, McLeod, believe the treatment to be worthless.

Röntgentherapy.

As far back as 1898 Kirrmission in Paris reports the successful treatment of tuberculosis of the wrist in a boy of 17 years. Scattered reports occur in the literature from time to time: so especially are the writings of Iselin, Wilms, Baisch, Bardenheuer, and New.

The rays seem to disintegrate the tuberculosis granulations, thereby setting free substances toxic to the bacilli. It is not

claimed at present that this treatment is to be used on the epiphyses of children under 14 years of age, owing to injury to the epiphyses and retardation of growth.

Most authorities advocate the use of an aluminum plate to shut off the soft rays which might burn the skin. It is the rule of most authorities to treat until erythema develops and then discontinue for two weeks. Iselin does not believe it necessary nor wise to cause erythema.

The ray does not improve the large joints. Pretty generally it is reserved for the hand, wrist, elbow and ankle. The treatment is naturally slow and should be continued for weeks and months. Those who have done most work along this line laud the treatment extravagantly, and among these are a number of surgeons as well as roentgenologists. From a review of the literature I would allot to the X-ray a subordinate place in the treatment of joint tuberculosis. There is very little written about it in American surgical literature. On the other hand, as against heliotherapy it can be carried out at any time, in any place and at much less expense.

Heliotherapy.

The treatment of joint tuberculosis by exposure to the sun's rays gives the most astonishing results, which I believe are too little appreciated by the profession at large. The reason for this lack of appreciation is patent. Sun-treatment requires many months and it may be several years to effect cure. The treatment is by all odds best undertaken at sanatoria in the mountains, and most of the patients have not the money.

The great pioneer in heliotherapy is Bernhard in Switzerland, followed, in 1903, by Rollier also working in the Swiss Alps at Leysin. These men working in sanatoria at altitudes of 3,500 to 4,500 feet, taking in all forms of surgical tuberculosis, at all ages, have published results that would seem to make absurd the operative diligence of Volkmann of a decade before. For a

detailed account of the method I would refer the reader to the numerous papers of Rollier and to the recent papers of Dietrich and of Rothschild. In brief, the patients are first detained in bed for several days to acclimate them to the altitude. They are then exposed either entirely (Rollier), or partially (Bernhard) to the sunlight, at first for five or ten minutes and gradually up to 7 or 8 hours per day.

It is aimed to have the patient well tanned by the rays. Except in spondylitis, plaster is not used, but the patients are immobilized in extension apparatus. No surgical interference is performed or necessary. The patients in the matter of a week or so gain in strength, appetite and spirits. Tuberculous abscesses disappear, sinuses close, and ulcers skin over. Even bony sequestra are cast off, and what is more the joints in very many instances heal with retention of motion. All patients are kept in bed during treatment.

According to Bernhard the cure is effective through the actinic rays of the sun in that they destroy the bacilli, and through the hyperemia of the tissues, cause increased metabolism, and the production of anti-toxin; there also is the general effect due to increased nutrition.

In one publication, out of 369 cases, Rollier announces 78.3 per cent cured and 13 per cent improved. In his last publication of over 700 cases he gives the following results:

Of 95 cases of spondylitis, 77 cures.

Of 81 cases of coxitis, 59 cures.

Of 67 cases of tuberculous knee, 59 cures.

Of 20 cases of tuberculous elbow, 18 cures.

These statistics deal with both children and adults, both closed and fistulous cases.

It would seem that almost every visitor to Rollier's clinic comes away an enthusiast. Such active surgeons as Bardenheuer, von Eiselsberg and Hochenegg all have published endorsements of Rollier's results. Leuba in a recent paper gives the results of

94 cases of tuberculosis of the foot treated in Rollier's clinic with the sun's rays since 1903. Of these 94, 42 were suffering from fistulae and were brought to Leysin as the last resort before amputation. The most of the remainder were suffering from other forms of tuberculosis and came to the institute in a serious condition. The youngest patient was two and one-half years old, the oldest sixty-seven years. The localization of the disease was, in 54 cases, in the tibio-tarsal joint, and in 11 the calcaneus, in 19 the tarso-metatarsal joints and in 10 the tarsal joint. Investigation in December, 1912, showed that of the 35 cases without abscess, 33 were cured, and two improved; of 17 cases without abscess, 15 were cured, one stationary, and one death; and of 42 cases with fistulae 39 were cured, two improved and one stationary. Leuba states that many cases suffering from the disease from two to eight years and treated by means of injections of iodoform and tuberculin, partial resection, etc., and who entered the institute in a quite hopeless condition, were cured within a year by heliotherapy.

The cost of the treatment is the great drawback. Heliotherapy can be carried out in the lowlands and in cities, but the sun seems to lose much of its power by filtering through the atmosphere. However, Joachimsthal in North Germany, Jerusalem in Vienna and Bardenheuer in Cologne have gotten very good results in the lowland. Of all conservative forms of treatment this would seem the most effectual.

Passive Hyperemia.

Bier's treatment has undergone changes in the course of time. At first Bier used stasis for a day at a time, but experience showed that oedema, secondary infection, erysipelas, and cold abscesses became frequent complications. He made the rule therefor some years ago to apply treatment twice a day for an hour at a time, and to treat for many months. Secondaries are so avoided.

It is necessary to get the right grade of stasis. The members should be warm during the treatment, not cold, and pulse should be felt. It is improper to have deep cyanosis of the part. Bier recommends in some cases the preliminary use of the hot air bath.

Bier does not immobilize the part, nor does he combine the stasis with injection of iodoform-oil, or other chemicals. The treatment is very long: rarely is cure effected under nine months, and often not under eighteen months. He claims .80 per cent cures in hand tuberculosis; 73 per cent in elbow and 62 per cent in foot.

In a late paper Bier claims that the complications which he used to encounter such as oedema, secondary infections, and cold abscesses, he now avoids by the use of potassium iodide in large doses, which he claims has an antiphlogistic influence. He gives fifteen grains to two drachms per day and says that thereby he can use stasis three times a day for four hours at a time. He has cited exceptionally good results with this method.

Injection of Joints.

Of the treatment of joint tuberculosis by injection, I shall say only a word. Iodoform in oil or glycerine, phenol, iodine, and formaldehyde are the chemicals which have been used. The formaldehyde treatment introduced by Murphy, in this country, is the most widely used at present. The solution is 2 per cent liquor formaldehyde in glycerine prepared at least twenty-four hours before use. The amount used is 10 to 20 cc.

Operative Treatment.

Operative treatment of joint tuberculosis is almost exclusively reserved for adult patients. Joint tuberculosis in children is always treated conservatively except in very bad cases.

The types of operation are incision and drainage, which has fallen into disuse, excision and resection. The object of opera-

tion is two-fold, to remove the tuberculosis tissue and to destroy motion in the joint.

The weight of opinion is toward operative measures in adults. There are not many men who claim cures of the tuberculosis process in adults by rest and plaster casts. Then, too, the adult is mostly a wage earner and can not afford the long time necessary for conservative treatment. Resection is the operation mostly used. Cold abscesses are never opened, but are aspirated. Amputation is the operation of choice in very old or debilitated subjects.

The wrist, hip and spine are the joints which give the poorest showing, after operation. These joints are in general best treated conservatively even in adults.

Tuberculosis of the elbow, ankle, or shoulder is best treated by resection. Tuberculosis of the knee is always resected in adults. Severe cases in children are also best treated by resection. It is true resection hinders further growth, but so does conservative treatment.

To conclude, the foregoing has been intended as a delineation of the methods advocated by the leading writers and workers today on the subject. Which one of all the methods advanced shall be used in our next case? This we can not say in advance. Everything in connection with the patient must be taken into consideration. My own view is in general to use operative methods in adults and not to operate on children, but I sometimes think that my ideas on operation in these cases are biased by inexperience with conservative methods.

515 Franklin St.

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THE DIAGNOSIS OF PULMONARY TUBERCULOSIS*

and

THE TREATMENT OF TUBERCULOSIS.†

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Tuberculosis of the lungs is essentially a chronic disease. Miliary tuberculosis, an acute infection and difficult of diagnosis, often mistaken for typhoid fever, usually lasts after the lungs are involved about three months, is not considered in this paper. My remarks shall be confined to the diagnosis of the usual form of tuberculosis of the lungs, endeavoring to emphasize the early signs of the disease and how these signs may be elicited and interpreted.

The first and very important consideration is a complete history—family and personal. The patient should be allowed plenty

of time to tell his own story of his ailment in his own way. By such a method the principal symptoms as they appeal to the patient are obtained. Points of importance in the history may be elucidated by a few well directed questions.

We will consider the subjective symptoms that have been elicited in the history.

SUBJECTIVE SYMPTOMS.

Loss of Appetite. Usually an early symptom. Not present in every case. Appetite may vary, one day good, another day limited.

Digestive Disturbances. A late symptom as a rule; however, may be present early.

Loss of Weight. May be the first symptom the patient notices. Especially is this true in young people. Older persons do not weigh themselves as often as the young.

Shortness of Breath on Exertion. A very early symptom. Is not due to the extent of lung involvement, but rather to the weakness from the infection. This symptom is also noticed early in young patients because they take more exercise than older persons.

Weakness, Lassitude. The early cases will call attention to this condition. Manifested by lack of energy in their work, disinclination to take exercise or walk long distances; a tired feeling. May sleep well, but wake of mornings feeling tired and languid.

Constipation. Very frequently an early symptom, possibly due to inability to eat sufficiently. It is nearly always present in a woman patient, especially in the beginning of the disease.

Diarrhea. Usually a late symptom and in most cases due to the extension of the infection to the bowels.

Pain. Usually a late symptom and due to involvement of the pleura. If an early symptom is confined to apices of lungs and also due, in most instances, to pleura involvement. Quite frequently, however, there is pain at the base of the lung opposite the one involved in the tuberculosis process and a slight pleurisy may be present at this point.

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

†Read before the Duval County Medical Society at Jacksonville, June, 1913.

Many cases terminate fatally without pain having been experienced.

Cough. In early cases the patient is prone to deny the existence of cough. Inquiry, however, will elicit the admission of a slight clearing of the throat in the morning on getting out of bed or when first lying down at night. In more advanced cases cough becomes more and more pronounced and often very exhausting. In the late cases cough is one of the most constant and troublesome symptoms.

Expectoration. Patient will not admit of this symptom in early cases, until closely questioned, when a slight amount of expectoration is admitted, especially in the morning when dressing. Further interrogation will elicit a slight cough with expectoration when exercise is taken or extra physical effort is made. In late cases expectoration is usually abundant.

Night Sweats. Not an early symptom unless the patient is becoming rapidly weak. When the tuberculosis follows, or concomitant with, other debilitating disease, night sweats appear very early. The patient becomes more concerned about the sweats at night than possibly any other manifestation of the disease, because he thinks they produce the weakness and lassitude. Night sweats are frequent in advanced and late cases.

Chilly Sensations. Patient often complains of this symptom in early cases. He notices it most in the early afternoon. It is a frequent symptom in the advanced cases.

Hemorrhage. May be the first symptom the patient notices, but it is not the first symptom, if a good history is obtained. Many cases do not have hemorrhage during the entire course of the disease, but the majority do at some time have hemorrhage.

OBJECTIVE SIGNS.

Pulse. Rapidity of the pulse is an early sign, if not the earliest manifestation of the disease. In estimating the rate of the pulse the degree of excitement occasioned by the examination must be considered. Effort

should be made to count the pulse while engaging the patient in conversation foreign to the subject of disease. For comparison the pulse should be counted during rest and after exertion. The pulse of tuberculosis is usually a feeble pulse even in the early stage of the disease.

Blood Pressure. A low blood pressure is not always an early sign of pulmonary tuberculosis. It is important and worthy of consideration if the systolic pressure is 110 or lower. The age of the patient must be considered. In well developed cases the blood pressure is nearly always low except in old people with blood vessel changes. However, we seldom have occasion to examine old people suffering from tuberculosis.

Fever is an early symptom especially in the afternoon. The morning temperature may be normal or sub-normal. If possible the temperature curve should be observed for several days taken at three or six hour intervals. Rest and inactivity may and usually does reduce fever. A point to be considered. A constant afternoon rise of temperature, be it ever so little, in a patient attending his usual duties, must be looked upon as extremely suggestive of tuberculosis.

Physical Signs in Chest Examination are enumerated and elucidated in textbooks and to take up the time allotted to this paper with them would be only a repetition and I shall merely touch on certain points emphasizing their importance.

No chest can be examined satisfactorily that has clothing on it. The patient should be stripped to the waist and standing or sitting in an erect position in front of the examiner.

Inspection reveals shape of chest, depression above and below the clavicles, degree of adipose tissue or emaciation, degree of movement during normal respiration, bulging of one side or other, color of skin, position of apex beat of heart.

Palpation and percussion in early cases may be of little service except in children

and very thin adults. In advanced cases palpation and percussion are valuable procedures and corroborative of other findings. In every chest examination these procedures should be employed.

Measurements. Measuring the chest affords the examiner opportunity to observe the degree of movement during respiration. After measuring the entire chest one side should be measured at a time in order that comparison be made.

Auscultation. Since the time of Laennec, who, for the first time presented the subject of auscultation in so concise and scientific a manner, this procedure has been of most value in examinations of the organs situated in the thoracic cavity. This occasion does not demand a reiteration of the signs elucidated by the breath sounds to the ear of the acute examiner. Emphasis, however, should be placed on the use of a good stethoscope, one the physician is accustomed to use, one with a small or medium size bell-shaped piece of gutta-percha at the single end, the ear pieces of the same material and well fitting. With the small bell-shaped piece the spaces between the ribs can be better examined. Breath sounds are better heard between than over or through the ribs. The examination should be made under normal respiration first, then forced breathing may be requested of the patient. Forced breathing expands air vesicles that are not used under normal respiratory action and necessarily air entering and leaving these unused cells during forced breathing produces for a short time abnormal sounds and may lead the examiner to erroneous conclusions. The entire chest, front and back, must be carefully ausculted, as tuberculosis of the lungs does not always begin in the apices.

Examination of the Sputum. Microscopic examination of the sputum should be made whatever the physical findings. Tubercle bacilli in the sputum is corroborative and may be found before the changes in the lung tissue make a physical examination

positive. However, if physical examination renders the subject suspicious, repeated examinations of the sputum should be made for the bacilli. The bacilli do not appear in the sputum until the rupture of the tubercle, the characteristic lesion of tuberculosis.

SUMMARY.

Pain in the chest may or may not be a symptom of tuberculosis of the lungs. Usually there is no pain.

Loss of appetite is a suggestive early symptom.

Loss of weight appears early in the disease and demands careful consideration.

Increase in pulse rate possibly the earliest symptom.

Cough even of slight nature and not noticed by the patient is suggestive. Cough of any consequence lasting over a month or two in young adults is usually of tuberculous origin.

Hemorrhage from the lungs is usually a late evidence of the disease. May not occur at any time, even in fatal cases, but may be an early symptom. Free hemorrhage from the lungs means tuberculosis in 75 per cent to 80 per cent of cases.

Digestive symptoms occur late as a rule. The skin and conjunctiva reactions to tuberculin are of no value in adults. In children before the age of five either reaction is valuable. It is questionable if it is ever necessary to use the conjunctiva for the test.

Blood pressure is usually low.

THE TREATMENT OF TUBERCULOSIS.

In discussing the treatment of tuberculosis I shall confine my remarks more particularly to that form of the disease limited to the lungs and contiguous structures.

A short paper on this subject must necessarily touch the essentials and the latest consensus of opinion, hence I shall not mention before a learned body of medical men

what the intelligent laity already have knowledge of.

The disease for purposes of convenience is divided into three stages: Incipient, moderately advanced and advanced, and the treatment and management of each stage is modified necessarily to meet the conditions. In the incipient stage our energies are directed toward the patient himself. In the moderately advanced stage, to both the patient and those who come in contact with him, and in the advanced stage, to those who have the care of the patient. I do not mean that the patient is neglected in any respect in these latter stages, but that effort is more directed to prophylactic and preventive measures, hospital and sanatoria treatment.

Climate. We recognize climate as having a beneficial influence in all stages of the disease but more especially in early cases; the catarrhal type of the disease by reasonably high altitude and dry atmosphere; the fibroid type by a warmer atmosphere and lower altitude. Climate is only measurably beneficial and the disease is better controlled where abundant fresh air, sunshine and wholesome food is readily and easily obtained combined with a maximum of clear days and sunshine. Another very important point in considering climate should be the environment and congeniality of surroundings, that is, friends and those interested in the patient and the amount of his resources should be taken into serious consideration. A rich patient may buy attention and interest, a poor one cannot. The poor tubercular had better be at home with family and friends.

Fresh Air. Fresh air and plenty of it day and night. Many and various devices are obtainable or can be constructed to surround the patient constantly with this essential, whether he is up and about or confined to bed. With these you are all familiar.

Rest. Rest is perhaps the most important requisite to satisfactory results; especially if the patient has an elevation of temperature.

Every tuberculosis patient should be in bed or in a reclining chair, couch or hammock when fever is present. During the morning hours when no fever is present patient may be up and dressed and may take a restricted amount of exercise. Rest and the recumbent posture is essential and probably the best procedure in case of hemorrhage. I question the potency of drugs arresting hemorrhage from the lungs. Morphia or codia is the only drug worth consideration and may be used to advantage.

Sunshine. Exposure of the tubercular to the direct rays of the sun for a considerable length of time has proven detrimental. Better results have accrued from sitting or reclining in the shade on clear days.

Food. The food question in these patients resolves itself into the use of pure, fresh and wholesome products, easily obtained, easily digested and assimilated. The foods that require a minimum amount of digestive and assimilative energy and leaves a minimum amount of residue are the foods of choice. Any and all foods should be served attractively and with care for cleanliness. Consult the patient's wishes, cater to his palate and gustatory desires. When the diet is restricted milk and eggs are the most easily administered and most easily digested. Purity of the milk and freshness of the eggs of course are essential. Mixed diet appeals to some, restricted to others. Individualize and give such food as each case can take care of and digest easily. Baths and the proper amount of bodily cleanliness must not be overlooked. Mental and physical relaxation through various entertainments and congenial social intercourse produce a tranquil state of mind and body.

Sera, Vaccines, Bacterius. The question of the usefulness of sera, vaccines and bacterius in pulmonary tuberculosis is subjective and I approach it with trepidation. Many observers report good results, others question it. These adjuncts are usually employed in sanatoria where the time-tried fresh air and good food is used and it is

difficult to attribute the results obtained to one or the other. I must admit my skepticism of the usefulness of these agents *per se* in pulmonary tuberculosis. In bone, joint and glandular tuberculosis their administration meets with favor.

Drugs. Drugs are useful but must be used with discrimination. You will recognize their limitations as I mention them: Belladonna, atropine, aromatic sulphuric acid for night sweats. Creosote, if tolerated by the stomach, for irritating cough. Morphia, codia or heroin for cough and to produce sleep, but caution is urged in the use of these latter or any preparation of opium. In the tuberculosis subject the gastric and intestinal secretions are loosened, hence digestive agents may be used with benefit. Hydrochloric acid, the bitter tonics, nux vomica, gentian and calumba. For constipation mild laxatives, as cascara sagrada, olive oil, aloes, etc. Patients on restricted milk and egg diet often require more active measures as castor oil, calomel or salines. For diarrhea bismuth offers the best results. Arsenic as a reconstructive agent is employed for a short period with good results.

I have merely touched the surface of the subject of the treatment of tuberculosis and I hope the discussion will elucidate any contending point.

I will mention in closing that the production of artificial pneumothorax with nitrogen gas is meeting with favor with some observers.

RENAL TUBERCULOSIS.*

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Tuberculosis of the kidney occurs as two distinct types: Acute miliary tuberculosis, a part of a general widespread infection; and chronic ulcerative tuberculosis. It is the latter type which is amenable to treatment,

and with which this paper has to deal. The kidney is the organ of the urinary system which is primarily involved in 70 to 90 per cent of the cases of tuberculosis of this system; and the route of the infection is by the blood stream, as a direct hematogenous infection, in about the same percentage of instances. The bacilli get into the circulation either by passing through, and not involving the bodily filters, as the tonsils, and lining of the intestinal tract; or from some other focus in the body.

The kidneys are involved in 5 per cent of all cases of early tuberculosis, and in about 25 per cent of the late cases, so the disease is not a rare one. Fortunately it begins as a unilateral infection in at least 90 per cent of the cases, and remains so over a period of months, giving ample time for an accurate diagnosis and proper treatment before it becomes bilateral.

Braasch found that 86 per cent of the cases coming to the Mayo clinic for surgical treatment were unilateral, and that the cases showing bilateral involvement, had had symptoms of the disease over a period of from two to ten years.

The complete diagnosis of the disease is necessarily made in two installments, and with the proper amount of care can be made relatively early and easily. The first installment is made by the man on the firing line—the man in general practice. He is the man upon whose shoulders rests the burden of the initial classification of cases; and he can usually, by the proper use of the facilities at his command, say whether a case is or is not one of tuberculosis of the urinary tract. When he does this and does it early in the course of the disease, he has done his work well.

The second installment in the diagnosis relates to the accurate location of the pathology, its extent, and its amenability to surgical treatment; and is necessarily made by one who is equipped to do accurate work with the cystoscope, functional tests, laboratory methods, etc. These methods have

*Read before the Duval County Medical Society at Jacksonville, June, 1913.

revolutionized renal surgery, and the data obtained by their use is absolutely indispensable to the operating surgeon.

Whether or not, however, the patient receives the benefit of these accurate diagnostic procedures, is wholly dependent on whether or not his family physician makes the first installment of the diagnosis properly; and having so done, is cognizant of his responsibility in the case. In summing up his diagnostic evidence from the history of the case, the physical examination, and the examination of the urine, the following points should be kept in mind:

1. First and most important is the recognition of the fact that the bladder is the mouthpiece of the whole urinary apparatus; and through it complaints from other parts of the apparatus are usually first made known to the examinee, and hence to the examiner. Cystitis, without some qualifying clause relative to its cause, is not a diagnosis, and should never be given nor accepted as such. It is no more of a clinical entity than indigestion.

2. The first symptoms complained of by the patient with tuberculosis of the kidney, in 80 per cent of the cases, are those of bladder irritability—frequency and urgency of urination, especially nocturnal. When these symptoms come on insidiously, and progressively increase in severity in young adults, it should at once throw suspicion on the kidney as the seat, and tuberculosis as the type of the existing pathology.

3. About 20 per cent of the cases of renal tuberculosis in males show some demonstrable tuberculous involvement of either the epididymis, testicle, prostate, or seminal vesicles.

4. Palpation of the kidneys is unsatisfactory and often misleading, due to the fact that if an enlarged and tender kidney is found, it is difficult to say whether it is the diseased organ, or the normal organ, secondarily hypertrophied and congested from the increased demands upon it consequent upon the destruction of its fellow.

5. Fist percussion over the costo-vertebral angle is highly recommended by Murphy as a differential diagnostic sign, but I have not been able to obtain the happy results with it which he describes.

6. Urine examination gives us the most positive evidence in the construction of our diagnosis, and should be most frequently and painstakingly made, with special reference to the following points:

- (a) The quantity gradually increases in amount up to a definite polyuria as the case progresses.

- (b) The specific gravity is persistently low.

- (c) The color is light amber to colorless unless tinged by blood, and if there is much destruction of kidney substance, as in bilateral disease, it usually is as colorless as water, and has scattered through it the typical white flecks of pus.

- (d) Frank hematuria occurs as the first symptom of the disease in only about 6 per cent of the cases, but microscopic blood may be found in a large number of the cases showing pus.

- (e) Microscopic examination of the urine from a case of tuberculosis of the kidney will practically always show pus; will usually show a few red blood corpuscles, and will, in 75 per cent of the cases, show tubercle bacilli. It should be frequently and thoroughly examined for these constituents.

- (f) Care in the taking of the specimen can not be too strongly emphasized, as voided urine containing leucorrheal discharge, menstrual blood, smegma bacilli, etc., is absolutely worthless from the standpoint of differential microscopic diagnosis.

Attention to the above points takes up considerably more time than the asking of a few questions, and the giving of a prescription for urotropin; but the reward in satisfaction to the patient, and to the physician, is well worth the time spent. When a positive, or even a tentative diagnosis of tuberculosis of the urinary apparatus is made, the

case should at once be given the benefit of a thorough cystoscopic examination for the accurate determination of:

(a) The source and distribution of the pathology; (b) the amount of destruction to the organs which the pathology has caused; (c) the advisability of their surgical removal, and the capability of the remaining organs of sustaining life in such event. An accurate knowledge of the above facts is absolutely essential to the proper handling of the case, and that knowledge can be obtained by the use of the cystoscope, ureteral catheters, the renal functional tests, and the clinical laboratory, including guinea pig inoculation. The technique of these procedures is manifestly out of place in a paper of this scope, so it is omitted.

Though an occasional case of renal tuberculosis is cured medically, it is essentially a surgical disease. That surgery offers the best hope of cure is now the consensus of opinion; based on compiled statistics showing a 3 per cent operative mortality with 75 per cent permanent cures, against 90 per cent mortality in cases not operated upon.

Nature's aim in the treatment of tuberculosis in any part of the body is to remove it. She does this by completely surrounding the focus of infection with fibrous tissue. Her efforts along this line in renal tuberculosis are occasionally found in what has been called an auto-nephrectomy, where she has caused a fibrous obliteration of the ureter, and a consequent cutting off of the escape of tuberculous debris from a dead kidney into the bladder.

The tuberculous kidney, due to its intimate anatomical relations with the bladder, and through the bladder with its fellow, and with the other organs of the urinary system, offers to nature a very arduous task in preventing the spread of the infection. At the same time, however, due to these same anatomical relations, and due to nature's generosity in giving us a duplicate organ, it offers to the surgeon peculiar advantages in its radical removal, which can not be found

in tuberculosis elsewhere in the body. So that nephrectomy is now the accepted treatment for renal tuberculosis, as soon as a definite diagnosis is made. It is a relatively safe, sound, and conservative procedure; leaves behind it little permanent morbidity; and has a large percentage of permanent cures to its credit.

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LABORATORY DIAGNOSIS OF TUBERCULOSIS.

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In discussing a topic like the laboratory diagnosis of tuberculosis, one naturally thinks, first, of the examination of sputum for tubercle bacilli.

This has been regarded by practitioners and laboratory men as one of the most reliable tests for the presence or absence of the disease.

It would seem, that the matter of making examinations of sputum, to determine the absence or presence of tubercle bacilli, is such a simple procedure that no elaborate discussion should be necessary.

In the work of a public health laboratory, certain matters occur at what, one might say, regular and frequent intervals, which impress the laboratory man with the need of giving much thought to the simple procedure of gathering sputum and sending it to the laboratory for examination.

It is a common occurrence, in the central laboratory of the State Board of Health of Florida, to receive specimens for sputum examination which do not contain material from the lungs or bronchial tubes. I might state here that our custom in sending out containers for submitting sputa for examination is fairly well known to the practitioners in the State, but for those who are probably not sufficiently informed on this, our sputum bottles contain approximately 5cc. of 5 per cent lysol solution.

The disinfectant is sent out as a safeguard against contamination by those who have to handle the specimens, and also in case of accident in the mails.

Many of the bottles which are returned, and supposed to contain sputa, fail to show that there is any sputum in the bottle, and naturally these specimens are negative.

In order to make the sputum examination satisfactory, it is necessary for the physician to instruct his patient that a simple expectoration of some of the salivary secretions into the specimen bottle is not satisfactory for the test. The patient should be instructed that the best sample is that coughed up the first thing in the morning, and that he should avoid, as much as possible, simply spitting in saliva or some of the nasal secretions.

Ravenel stated at the meeting of the Section on Hygiene and Preventive Medicine of the American Medical Association in Minneapolis in 1912, that the nature of the samples of sputa submitted for examination in public health laboratories was such that they were more of a detriment than a help in the early diagnosis of tuberculosis.

A person who has spent some time in the laboratory where this work is done, can readily see the logic in a statement of this kind.

There are, however, a certain number of cases where the tubercle bacilli may be found rather early, and where the positive finding, in the public health laboratories, furnishes information on the basis of which a few will be enabled to take up the fight against the disease and get well.

As is well known, most of the diagnoses, which are made in such laboratories, form positive findings of the sputum, are usually cases too far advanced to offer any hope of a cure.

Knowing these things, it is necessary for the physician to resort to some other method of making a diagnosis, and to depend upon the physical findings more than upon the

negative results of the sputum examination in the laboratory.

In reviewing our results for the past four years, in the laboratory of the State Board of Health of Florida, we find that of the total number of sputum examinations made, 24.74 per cent were positive; which means that one out of every four cases suspected of tuberculosis showed the tubercle bacillus on examination of the sputum. The percentage varies from 22.4 per cent in 1911 to 27.5 per cent in 1913.

One would scarcely think that all cases suffering with tuberculosis would present themselves so late that one in every four would show tubercle bacilli in the sputum. We know that patients have had the disease for two years without finding the tubercle bacilli in the sputum, and yet, when we consider the nature of the specimens submitted, we feel certain that a large number, which probably do have tubercle bacilli in their sputum, are negative because of improper samples.

The various other tests, namely, the tuberculins, do not strictly come under the head of laboratory diagnosis of tuberculosis from the standpoint of the public health laboratory, and I shall not go into the theory of these in the present discussion.

The main object of this paper is to emphasize the fact that not enough attention is given to the proper collection of sputum for laboratory diagnosis, and secondly, that in the vast majority of cases in general practice enough time is not spent in making a careful systematic physical examination of the patient. The high percentage of positive findings from our laboratory, in spite of the nature of a great many of the specimens, is almost conclusive evidence of this point.

PROPAGANDA FOR REFORM

ANGIER'S THROAT TABLETS.—These tablets are stated to be composed essentially of elm bark and petroleum and yet are claimed to "promote appetite and aid digestion."

The A. M. A. Chemical Laboratory reports the tablets to contain about 12 per cent. of soft yellow petrolatum, like that found in Angier's Emulsion. (*Jour. A. M. A.*, Sept. 12, 1914, p. 964.)

ANGIER'S EMULSION.—A report of the Council on Pharmacy and Chemistry points out that when Angier's Emulsion, Angier Chemical Co., Boston, Mass., was first put on the market it was advertised as a "food-medicine" and an "Ideal Substitute for Cod Liver Oil." Although the manufacturers now advertise this product as a laxative and state it to be "purely mechanical in its action," they still mingle with the new ones the old claims of "tonic and reconstructive merits" and thus attempt to perpetuate the erroneous belief that the preparation has nutritive value. As to the identity of the petroleum product contained in the preparation, regarding which the advertising circulars make contradictory statements, the A. M. A. Chemical Laboratory reports that this has all the properties of soft yellow petrolatum. (*Jour. A. M. A.*, Sept. 12, 1914, p. 962.)

ANTISEPTIC ACTION OF HEXAMETHYLENAMINE.—The former opinion that hexamethylenamin possesses antiseptic action independently of the liberation of formaldehyd, was an assumption not founded on reliable experimental evidence. The recent investigations of Burnam, Hanzlik and others have shown that its action as an antiseptic depends on the decomposition into formaldehyde and ammonia which occurs only in an acid medium. (*Jour. A. M. A.*, Sept. 12, 1914, p. 962.)

DIGALEN OMITTED FROM N. N. R.—In view of increased extravagance regarding the claims made for Digalen by the Hoffmann-LaRoche Chemical Works, the Council on Pharmacy and Chemistry decided to investigate the present eligibility of Digalen. Examination demonstrated that the asserted presence in Digalen of "amorphous digitoxin" was not substantiated by evidence, that Digalen and Digalen Tablets were not

constant in composition and action and that the claim that Digalen causes less gastric disturbances than digitoxin was unfounded. While the manufacturer promised to hold the claim that Digalen contained "amorphous digitoxin" in abeyance, they refused to concede the variable composition of Digalen and reasserted that Digalen was less liable to cause gastric irritation than other digitalis preparations. In view of the overwhelming evidence that Digalen is variable in action and in composition and that it produces the same gastric disturbances as other digitalis preparations, the Council voted that Digalen and Digalen Tablets be omitted from N. N. R. (*Jour. A. M. A.*, Sept. 5, 1914, p. 881.)

DOSE OF DIPHTHERIA ANTITOXIN.—While 3,000 units, the dose given in the Pharmacopoeia, probably is a sufficient initial dose in many cases, this quantity is not enough to satisfy the factor of safety. There is a growing opinion that no case of diphtheria should receive less than 10,000 units as the initial dose. (*Jour. A. M. A.*, Sept. 5, 1914, p. 873.)

LIQUID SOAP.—The following economical formula has been proposed. It may be flavored and colored to suit: Sodium hydroxid, 55 gms.; potassium hydroxid, 65 gms.; cottonseed oil, 800 c. c., alcohol, 500 c. c., and water to make 5,000 c. c. (*Jour. A. M. A.*, Sept. 26, 1914, p. 1129.)

PERTUSSIS VACCINE.—The Bordet Gengou bacillus is recognized as the cause of whooping cough and a vaccine prepared from it is used with success, although it is the general experience that when a child is already in the stage of incubation, the vaccine will not prevent the development of the disease. (*Jour. A. M. A.*, Aug. 29, 1914, p. 796.)

POISONING BY BORIC ACID DRESSING.—While wet boric acid dressings are harmless, this is not true of dry, powdered or crystallized boric acid. Alarming symptoms resulted from the application of dry boric

acid to wounds caused by a burn. (*Jour. A. M. A.*, Aug. 15, 1914, p. 593.)

PODOLAX.—A report from the A. M. A. Chemical Laboratory shows that PoDoLax, claimed to be "Podophyllin with the Gripe taken out," is a phenolphthalein nostrum. PoDoLax is being extensively advertised by the E. E. Sutherland Medicine Company of Paducah, Ky. From the analysis made, it appears that PoDoLax is an aromatized syrup, containing phenolphthalein in suspension and fortified by the addition of an extract of senna. Its laxative action is due chiefly to the phenolphthalein of which each dose contains about 1.8 grain. Podophyllin was not found to be present. (*Jour. A. M. A.*, Aug. 15, 1914, p. 595.)

RADIUM IN CANCER.—Radium can be used successfully to destroy growths on the surface whose entire extent can be exposed to its energy. Extensive growths involving deep structures and disseminated growths are beyond its control, and there is no reason to believe that they will ever be brought within its control. The effects and the eliminations of radium in the treatment of cancer are the same as those of the Roentgen ray. (*Jour. A. M. A.*, Aug. 29, 1914, p. 787.)

SANATOGEN.—Testimonials for Sanatogen are published which show good results in cerebral concussion, alcoholic gastritis, anemia, etc. The patient is given a chance to recover by rest, a proper diet and Sanatogen—and the recovery is attributed to Sanatogen. Based on some biological experiments the exploiters of Sanatogen assert that "Sanatogen acts as a strong stimulus as far as the recuperative powers of the blood are concerned." These experiments were repeated by Professor A. J. Carlson, of the University of Chicago, using Sanatogen, casein, casein and glycerophosphates, milk and crackers and milk. Prof. Carlson's experiments show that the effects produced by Sanatogen are not different from those obtained when casein, casein and glycerophosphates, milk and crackers and milk are

used. (*Jour. A. M. A.*, Sept. 26, 1914, p. 1127.)

SCARLATINA VACCINE.—The so-called scarlatina vaccine is said to consist of killed streptococci from scarlet fever cases. While the infectious agent of scarlet fever has not been established, the close association of streptococcus with scarlet fever has been considered a warrant for the use of anti-streptococcus serum, and various vaccines prepared from this organism, in the treatment of scarlet fever. (*Jour. A. M. A.*, Aug. 29, 1914, p. 796.)

SHORTAGE OF DRUGS.—In view of possible drug shortage, physicians should bear in mind that many proprietary foreign preparations are made and sold in the United States under their descriptive names, thus dionin as ethyl morphin hydrochlorid, urotropin as hexamethylenamin and Diuretin as theobromin sodium salicylate. (*Jour. A. M. A.*, Aug. 22, 1914, p. 692.)

SIGNIFICANCE OF THE WORD "LUTEIN."—The word "Lutein" has long been applied in physiologic chemistry to designate a group of fat-coloring matters which occur in nature and which have more recently also been given the general designation of lipochromes. As a rule the use of the term has been restricted to the yellow coloring-matter which develops in the ovarian structures. It is unfortunate that lately various preparations of dessicated corpora lutea from animals are being sold as lutein. (*Jour. A. M. A.*, Sept. 29, 1914, p. 1119.)

SODIUM VERSUS POTASSIUM SALTS.—The probable shortage of potassium salts due to the war suggests that sodium salts may in most cases be substituted without disadvantage. In general potassium salts have no marked superiority over the corresponding sodium salts. While the potassium compounds are said to be more active and to possess a more diuretic effect, the sodium salts are less depressing to the heart and in some instances less disagreeable to the taste. Sodium iodide, sodium bromide, sodium acetate, sodium citrate, etc., are just as effective.

tive as the corresponding potassium salts. (*Jour. A. M. A.*, Sept. 19, 1914, p. 1034.)

THE RADIO-ACTIVITY OF SARATOGA SPRINGS WATER.—An estimation of the radio-activity of Saratoga Springs Water, made by the United States Bureau of Mines, shows that the activity is due in the main to radium emanation, which is therefore readily lost, and not to dissolved radium salts. The total activity of the waters is rather low, that of the Crystal Rock spring, though not exceptional, is considerably above the average. The activity of different springs varies widely, some being more than twenty times as active as others. A similar variability is known to exist at Hot Springs, Ark., but only the vaguest information has been made public by our government. (*Jour. A. M. A.*, Aug. 29, 1914, p. 788 and 795.)

VACCINATION AGAINST SMALLPOX AND TYPHOID.—In view of the war, a general revaccination of the population of Paris has been ordered and huge quantities of anti-typoid serum have been prepared. (*Jour. A. M. A.*, Sept. 5, 1914, p. 873.)

VACCINE VIRUS NOT CONTAMINATED.—A study of cases shows that vaccinal tetanus is not due to contaminated vaccine virus. Further, since the law regulating the sale of biologic products in 1902 went into effect there have been examined in the Hygienic Laboratory of the U. S. Public Health Service over 1,500,000 doses of vaccine virus without a single specimen having been found to contain tetanus spores. Also, experiments indicate that tetanus will not be produced even if the virus used contains tetanus spores. Most cases of vaccinal tetanus are due to infection after vaccination. (*Jour. A. M. A.*, Sept. 19, 1914, p. 1032.)

VALUE OF TALCUM POWDERS.—The action of talcum powders on the skin depends on their protective and dehydrating properties. On the other hand they tend to form crusts and pastes, due to mixture of the powder with sweat or other secretions. There is

doubt if the boric acid in talcum powders can exert any antiseptic action. The action of the salicylated talcum powder of the National Formulary, though containing 10 per cent. of boric acid, depends on its salicylic acid. Commercial talcum powders contain small amounts of various antiseptics and perfuming agents and have little value from a therapeutic point of view. (*Jour. A. M. A.*, Sept. 26, 1914, p. 1129.)

VERACOLATE, MARCY AND CO.—Veracolate is a proprietary said to consist of the salts of the bile acids, sodium glycocholate and sodium taurocholate, with cascara and phenolphthalein. While bile salts are said to increase the secretion of bile, it is doubtful whether this increase in the secretion of bile is of value in the treatment of gall-bladder affections. There is no occasion for the use of bile salts combined with fixed quantities of cathartics, which should be added only when they are needed. The advertising claims for Veracolate show a tendency to extravagant statements. (*Jour. A. M. A.*, Aug. 1, 1914, p. 420.)

THE MODERN WARFARE AGAINST TUBERCULOSIS AS A DISEASE OF THE MASSES.—In some sections of the country as many as fifty per cent. of the children of parents attending tuberculosis dispensaries have been found on examination to be afflicted with tuberculosis of various types. We know also that children can also contract tuberculosis from others than their parents, as nurses, tuberculous relatives, boarders and strangers to the household, and we furthermore know that nearly ten per cent. of the children afflicted with tuberculosis have contracted the disease by the ingestion of tuberculous milk because the bovine type of the bacillus has been found in that percentage. We are as yet uncertain whether or not the bovine type of the bacillus of tuberculosis is transformed in later years into the human type by its new environment, but we do not worry about this uncertainty; we teach, preach and practice the prevention of tuberculosis in cattle by the enforcement of the tuberculin test and by weeding out the tuberculous cattle and prohibiting the sale of tuberculous meat and milk.—S. Adolphus Knopf, M. D., in *New York Medical Journal*.

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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THE TUBERCULOSIS PROBLEM.

To put the tuberculosis problem on a commercial basis may seem sordid, but since "Health is purchasable," a few figures may be considered.

Authorities value the life of an individual, from 15 to 40 years of age, at \$6,000 or \$8,000. This is the period of life of greatest economic production and the period of greatest economic loss in case of death. This is the period of life also when tuberculosis claims its majority. Two hundred thousand people die annually in the United States from this disease, entailing an economic loss, aside from the suffering, sorrow and sacrifice from the masses, amounting to the stupendous sum of \$1,600,-000,000.

It is estimated that, if a small part of this vast sum could be properly directed, each year, toward the prevention of the disease and the care and maintenance of those afflicted within a generation tuberculosis would be a rare and infrequent disease. Within the past decade the mortality from tuberculosis has decreased 18 per cent, due to the activities of social and civic organizations with the co-operation of health officials. Education of the public has been the keynote of action. If the next ten years is to bring the results of the past ten effort must not lag. Interest in the problem is essential and the more interest, the greater results. The community interest idea is the unit—the center—from which the larger groups of humanity receive inspiration for greater endeavor.

The health officer, city, county, state, of the proper kind, and there are many of them, if given substantial support, financial and legislative, will conduct the most fruitful campaign because of his knowledge of the causes and communicability of the disease and the hygienic and sanitary problems evolved in its eradication.

Every physician in the land has a duty to perform, and, owes it to the community in which he lives, in dealing with this disease

as with every other, and to him especially will the public look for a diagnosis in the early stages when the chances for recovery are greatest.

MEDICAL JOURNAL ADVERTISING.

THE JOURNAL wishes to again call the attention of our readers to the advertising columns of our publication. It will be noticed that our advertising patronage from outside the state is increasing from month to month. A number of these advertising contracts have been secured for us by the Co-Operative Medical Advertising Bureau of Chicago. This is not a commercial advertising agency run for profit but has been inaugurated by the Americal Medical Association for the purpose of assisting state medical journals to secure contracts and to keep their advertising pages *clean*. The only requirements this bureau calls for is that all journals receiving their support accept only advertisements complying with the rules of the Council on Pharmacy and Chemistry of the A. M. A. THE JOURNAL defined its attitude in this respect in its initial number and was therefore at once eligible for and received the support of this Bureau.

However, it is going to be necessary to convince the advertiser that he is spending his money with us to advantage. To simply know that an advertisement is being read helps not a little and a request for the advertisers' literature or for a sample of their products costs but a few moments' time and a postage stamp. We therefore urge our readers to look carefully over our advertising pages and let it be known that we are a live profession and have needs to be filled. If the members of the Florida Medical Association want a journal—not for a few months—but as a permanent institution, they must support those that make the publication of such a journal as our own a practical proposition. We urge every reader, therefore, to accept from the advertiser what he offers without charge for the pur-

pose of establishing the merits of his products, and then in every instance we further urge that our advertising patrons be given first consideration whenever it is within good business economics to do so.

ERRATUM.

Through a typographical error the degree of F. R. C. S., instead of F. A. C. S., was placed after the names of two of the collaborators in the October number of THE JOURNAL.

THE AMERICAN PUBLIC HEALTH ASSOCIATION.

As previously stated in the columns of THE JOURNAL the American Public Health Association will hold its forty-second annual meeting in Jacksonville from November 30th to December 4th. In connection with the meeting will occur a Southern Health Exhibition, the arrangement of which has been completed after untiring effort on the part of the committee having this exhibit in charge.

In addition to this exhibit the meeting will include a joint session with The National Mouth Hygiene Association.

The following papers comprise the scientific program:

The Negro Health Problem. L. C. Allen, M. D., Hoschton, Ga.

Housing Conditions of the Negro Population with Reference to Public Health. Ralston Lattimore, M. D., Savannah, Ga.

The Negro as a Problem in Public Medical Charity. Laurence Lee, M. D., Savannah, Ga.

The Influence of a Large Colored Population on the General Death Rate. Dr. Ernest C. Levy, Health Officer, Richmond, Va.

Syphilis Among Insane Negroes. S. S. Hindman, M. D., Georgia State Sanatorium, Milledgeville, Ga.

The History and Development of Industrial Hygiene with Special Reference to the United States. George M. Kober, M. D., Washington, D. C.

The Prevalence of Occupational Factors in Disease and Suggestions for their Elimination. E. R. Hayhurst, Chief, Survey of Occupational Diseases, State Board of Health, Columbus, Ohio.

Industrial Insurance. John B. Andrews, Ph. D., Secretary American Association of Labor Legislation, New York City.

The Federal Meat Inspection Service and Sanitation of Packing Houses under Its Supervision. George H. Shaw, Sanitary Engineer, United States Department of Agriculture, Bureau of Animal Industry.

Smallpox Epidemic at Niagara Falls. Linsley R. Williams, M. D., Deputy Commissioner of Health, State Department of Health, New York.

Educational Work on Sanitary Food Values in New York City. Donald B. Armstrong, M. D., Director, Department of Social Welfare, New York, Association for Improving the Condition of the Poor.

Registration of Communicable Diseases with Special Reference to Out-of-Town Cases. F. M. Meader, M. D., Director, Division of Communicable Diseases, New York State Department of Health, Albany, New York.

The Relationship of the Visiting Nurse to the Public Health Campaign. Ella P. Crandall, Executive Secretary, The National Organization for Public Health Nursing, New York City.

Health and Economic Results of Rural Depopulation and Abnormal Increase of Cities. Peter H. Bryce, M. D., Chief Medical Officer, Department of the Interior, Canada.

Life Extension. Prof. Irving Fisher, Yale University.

Sickness Insurance and Its Relation to Public Health. B. S. Warren, M. D., Sanitary Advisor, United States Commission on Industrial Relations, Washington, D. C.

The Newspapers and Public Health. Dr. W. A. Evans, Chicago, Ill.

Health and Economic Results of Rural Depopulation and Abnormal Increase of

Cities. Dr. Peter H. Bryce, Medical Officer, Department of Interior, Ottawa, Canada.

The Curse of Narcotism in America. Miss Jeannette Marks, New York City.

(Title to be announced.) Woods Hutchinson, M. D., New York City.

The Action of Certain Bacteria on the Nitrogenous Material of Sewages. E. G. Birge, Harvard University.

(a) Relative Stabilities in Polluted Waters Carrying Colloids. (b) Notes on the Practical Application of the "Saltpeter" Method for Determining the Strength of Sewages. A. Lederer, Sanitary District of Chicago.

The Use of the Cotton Disc Filter in Recording Sediment in Water. G. C. Whipple, Harvard University.

Examination of the Efficiency of Household or Domestic Filters. F. L. Rector, New York City.

The International Joint Commission's Investigation of Sewage Pollution of Boundary Waters. A. J. McLaughlin, International Joint Commission.

Chemical Disinfection of Excreta. W. Dreyfus, New York City.

Colon Bacilli and Streptococci and Their Significance in Milk. L. A. Rogers, Bureau of Animal Industry.

The Occurrence of Streptococci in the Milk of Healthy Animals. E. G. Hastings and J. M. Sherman, University of Wisconsin.

The Bacteriology of Ice Cream. H. D. Pease, S. C. Prescott and P. G. Heinemann.

The Sanitary Control of Shellfish Industries. C. L. Alsberg, Bureau of Chemistry.

The Fate of Bacteria in Frozen Meat held in Cold Storage and its Bearing on a Bacteriological Standard for Condemnation. J. Weinzirl, University of Washington.

Bacilli of the Diphtheria Group Isolated from Carriers and Convalescents. A. Wadsworth, M. B. Kirkbride and Ruth Gilbert, New York State Department of Health.

The Microscopic Examination of Feces for the Ova of Parasitic Worms with a Key

for Their Determination. P. E. Garrison, Thompson Pellagra Commission.

The Use of Inhibiting Dyes in the Isolation of Typhoid and Para-typhoid Bacilli. C. Krumwiede, Jr., New York City Department of Health.

The Use of Complement Fixation Reactions in a Public Health Diagnostic Laboratory. A. McNeil, New York City Department of Health.

The Laboratory as an Aid in the Diagnosis of Typhus Fever. J. F. Anderson, Hygienic Laboratory.

The Value of the Schick Test in Determining the Desirability of Immunization. W. H. Park, New York City Department of Health.

Best Time to Incubate Throat Culture. A. Gehrmann. Columbia Laboratory, Chicago.

The Typhoid Carrier Problem in Institutions, with Observations on the Widal Reaction, Following Administration of Typhoid Vaccine. E. M. Wade and O. McDaniel, Minnesota State Board of Health.

Wound and Skin Diphtheria. L. D. Bristol, University of North Dakota.

The Antagonism between the Diphtheria Bacillus and the Lactic Acid Producing Bacteria. Henry Albert, University of Iowa.

The Effects of Temperature Humidity and Air Movement upon Loss from a Moist Surface. E. B. Phelps, New York State Commission on Ventilation.

Results of the First Year's Experiments of the New York State Commission on Ventilation. C. E. A. Winslow, New York State Commission on Ventilation.

Bacteria and Dust Particles in Air. G. C. Whipple, Harvard University.

School Ventilation. D. D. Kimball, New York State Commission on Ventilation.

Methods of Bacterial Analysis. G. L. A. Ruehle, New York Agricultural Experiment Station.

Factory Ventilation. A. M. Feldman, New York City.

Municipal Health Officers and Venereal Diseases. Dr. W. A. Evans, Chicago.

The Marriage Certificate, A Deeply Rooted Social Problem. Dr. Oscar Dowling, President Louisiana State Board of Health.

An Investigation into the Relationship Between Flies and Diarrheal Diseases in Infants under One Year of Age in New York City. Philip S. Platt, M. A., Superintendent, Bureau of Public Health and Hygiene, New York Association for Improving the Condition of the Poor.

Rural Sanitation and Hookworm Disease. Dr. A. G. Fort, Georgia State Board of Health.

Some Observations on the Milk Situation. Prof. B. L. Arms, Galveston.

The Control of Yard Closets. Dr. Allen W. Freeman, State Board of Health, Virginia.

An Outbreak of Cowpox. Dr. A. J. Douglas, Health Officer, Winnipeg.

The Standardization of Public Health Work. Dr. W. S. Rankin, Secretary North Carolina State Board of Health.

The Value of a Credit Balance in Public Health Work. Dr. C. J. Hastings, Health Officer, Toronto.

Co-operation in Public Health Administration at La Salle, Peru, and Oglesby, Ill. Dr. G. F. Ruediger, Health Officer for above municipalities.

The Typhoid Carrier. Dr. Jessie B. Hudson, Director Clinical Laboratories, Clinton, Iowa.

Midwives, Their Influence on Early Infant Mortality. Dr. C. E. Terry, Health Officer, Jacksonville, Fla.

Practical Remedial Measures for the Betterment of the Hygienic Conditions of the Negroes. Dr. M. L. Graves, Galveston.

Cancer as a Public Health Problem. Curtis E. Lakeman, Executive Secretary, American Society for the Control of Cancer.

A Study of Methods of Sewage Disposal in Industrial and Rural Communities and their Possible Relation to the Spread of

Pellagra. Captain Jos. S. Siler, Medical Corps, U. S. A., Dr. Phillip E. Garrison, Passed Assistant Surgeon, U. S. Navy, Dr. Ward J. MacNeal, Assistant Director of the Department of Laboratories, New York City.

Water Supplies and Sewage Disposal. Dr. J. W. S. McCullough, Chief Health Officer, Ontario.

Experiments on Animals and Their Influence on Mortality. Dr. John H. Landis, Commissioner of Health, Cincinnati.

A Standard Certificate of Birth. Dr. W. A. Plecker, Registrar of Vital Statistics, Richmond, Va.

The Statistical Treatment of Non-Resident Deaths. Dr. Cressy L. Wilbur, Chief Division of Vital Statistics, Albany, N. Y.

How Shall We Treat Non-Resident Deaths? Mr. Henry Chalmers, M. A., New York State Division of Vital Statistics, Albany, N. Y.

Vital Statistics and the Physician. Mr. George H. Van Buren, Census Bureau, Washington, D. C.

The Importance of Autopsy Practice as a Basis for the Accurate Designation of the Causes of Death. Dr. Haven Emerson, Deputy Commissioner of Health, New York, N. Y.

On the Accuracy of American Cancer Statistics. Dr. F. L. Hoffman, Statistician, Prudential Insurance Company, Newark, N. J.

The Alleged Increase of Cancer. Prof. W. F. Wilcox, Cornell University, Ithaca, N. Y.

The Evidence from Life Tables. Mr. W. J. V. Deacon, State Registrar, Topeka, Kansas.

The Physical Characteristics of Garment Workers as Determined by the Examination of Three Thousand Subjects in New York City. Dr. J. W. Schereschewsky, Surgeon, United States Public Health Service, Washington, D. C.

Discussion of The Physical Characteristics of Garment Workers as Determined

by the Examination of Three Thousand Subjects. Dr. Robert Olesen, United States Public Health Service, Washington, D. C.

Physical Examinations of Employees Engaged in the Manufacture of Portland Cement. Dr. G. E. Tucker, Riverside, California.

The Place of Physical Examinations in Public Health Administration. Dr. Sigismund S. Goldwater, Health Commissioner, New York, N. Y.

Is the Tuberculosis Death Rate Declining? Dr. Philip Jacobs, Assistant Secretary, National Association for Study and Prevention of Tuberculosis.

Graphic Methods in Vital Statistics. Mr. A. R. Burnet, Presbyterian Board of Home Missions, New York, N. Y.

Introduction Statistics of Diseases—Their Present Status and Purpose. Dr. J. W. Trask, Assistant Surgeon General, Washington, D. C.

A Statistical Study of Whooping Cough. Dr. Frederick Crum, Assistant Statistician, Prudential Insurance Company, Newark, N. J.

Typhoid Fever. Dr. John S. Fulton, Secretary, State Board of Health, Baltimore, Md.

The Sequelae of Typhoid Fever. Dr. L. I. Dublin, Statistician, Metropolitan Life Insurance Company, New York, N. Y.

Puerperal Septicemia. Dr. W. H. Guilfoyle, Registrar of Records, New York City Board of Health, New York, N. Y.

Experiences with Refuse Disposal Works from the Point of View of Odors. Rudolph Hering, New York City.

Experiences with Refuse Collection and Disposal, with Reference to Odors. Samuel A. Greeley, Chicago, Ill.

Refuse Disposal in Southern Cities, with Particular Reference to Savannah, Ga., and Its New Refuse Incinerator. E. R. Conant, City Engineer, Savannah, Ga.

Recent Developments in Refuse Disposal Practice. Col. William F. Morse, New York City.

Report of the Committee on Refuse Collection and Disposal American Public Health Association. Samuel A. Greeley, Chairman.

City Waste Dumps. James W. Paxton, Washington, D. C.

Experience with Sewage Disposal Works with Reference to Odors. General Discussion led by the Committee on Sewerage and Sewage Disposal. George S. Webster, Philadelphia, Pa., Chairman.

The Use of Plant and Animal Life as a Measure of Stream Pollution. Prof. Stephen A. Forbes.

Sanitary Conditions of the Sangamon River. By Prof. Paul Hansen, Urbana, Ill.

The headquarters of the Association will be at the Seminole Hotel.

The following entertainment program has been arranged for the visitors:

December 1—Trip on the St. Johns river, with a buffet luncheon (or some other outing).

December 2—Assembly Ball for the members and their guests.

December 3—Musical Tea for the ladies, at the Country Club.

There will also be opportunities for side-trips, visits to neighboring orange groves, to Atlantic Beach, second only to Ormond Beach; to St. Augustine, only an hour distant, and to the famous Ostrich Farm, etc.

Everything points to the largest and most successful meeting in the history of this notable organization and it is admitted that the stimulus given Public Health work, especially in the south, will be far reaching.

FILTHY PAPER MONEY.

If we ask an Englishman what are some of the things which impress him in America, he is apt to reply with some choice remarks about our filthy paper money. This has happened to the writer several times. It would seem we have here a subject lately neglected and perhaps time-worn, but a very important one from a health point of

view. Europeans do not carry a roll of vile bills and we certainly do not give them credit for being any more particular about matters of personal cleanliness than ourselves! What can be more unsanitary than a roll of filthy, old, sour paper money that has been in the most vile spots imaginable? New bills for that matter are not particularly sanitary when compared with the common metals. Silver is a good germ destroyer, with copper and gold not far behind. In the summer time and in the South this sour odor is easily demonstrated in any banker's bill drawer. Perhaps many will smile at this and say that we are going too far to question the kind of money we handle just so we get it honestly. However, chances of infection by this means do come to everyone. We may be receiving the honest germs of tuberculosis or the spirochaete pallida of syphilis! The writer has had to sterilize bills handed him by syphilitics with lesions in their mouths who would wet their fingers with their lips and count out paper bills. An old friend (dentist) who rebels at the thought, tells me that he sterilizes all the paper money he handles! A good dentist to employ! Under this heading might come playing cards which we have often seen dealt by untidy persons who would distribute germs by wetting their fingers with their saliva when dealing. If this is a time-worn subject all the more reason not to abandon it. The remedy is not entirely in the hands of the people, money not accepted by one person at a bank is given to some one who *will* take it. Orders from Washington to bankers to return all slightly soiled bills at government expense would assist greatly. Here is an example of where a National Bureau of Health would do much. Let us as physicians work for a National Bureau of Health and cleaner money.

F. J. WALTER, M. D.
Daytona, Fla.

Reviews from Current Literature

THE ABDOMINAL CUTANEOUS REFLEXES.

Smith, Richard E.: *The Behavior of the Abdominal Cutaneous Reflexes in Acute Conditions Within the Abdomen and Pelvis.* Surg., Gynec. and Obst., 1914, Vol. XIX, No. 4, p. 504.

The writer states that while the abdominal reflexes have been utilized by neurologists as a means of differential diagnosis but little has been said regarding them in connection with local abdominal conditions. The writer states: "that the testing of the reflexes is very simple, takes but a moment, and needs no apparatus—points of practical importance. Care is, however, necessary in order to obtain reliable results, a fact emphasized by various writers. The abdomen may be divided into quadrants, an upper and lower one on either side. I employ any kind of dull instrument, usually the blunt end of a pencil. If this fails, I sometimes use a pin drawn lightly over the skin. The strokes should be full, rather light, and not too swift. It is applied in an oblique direction, parallel with the line of the groin and the edge of the ribs. The first stroke is apt to give the strongest response; after that it usually weakens or is entirely lost, a point of importance when the reflexes are weak. One must be careful not to encroach upon territory supplied by another reflex. If the reflex is present, an almost simultaneous contraction of the oblique muscles or rectus (or both) takes place, which when marked will pull the umbilicus to the side that is being tested. When weak only a fleeting and slight depression of the wall is produced. One must see that the muscles are not willfully put on tension, as it may weaken or destroy the response. Again, if the stroke causes pain, a voluntary contraction is apt to take place on that side of the abdomen or body, which, however, distinctly follows the stroke, but this will not deceive one if he is on his guard. Movements of the fat must not be confused with muscle contraction, an easy source of error in some cases."

"The reflex is a very constant one in healthy young individuals, fully as much so as the tendon reflexes. Müller and Seidelmann, examining one thousand healthy young soldiers, found the cutaneous reflexes always present with but one exception."

Smith, summarizing Müller and Seidelmann's findings in neurological conditions, states: "that these reflexes fail or are markedly diminished on the affected side of the body in spinal and cerebral hemiplegias of various origin, and that this symptom persists even after the disappearance of the motor symptoms. They fail on both sides in multiple sclerosis, and this is an early symptom of great value. They are usually exaggerated in early cases of tabes, failing in the late cases or in those that show an anaesthesia of the skin of the abdomen. The reflexes are retained in patients with spastic paralysis until a late stage is reached, and is a point of differential diagnosis between this disease and multiple sclerosis. In all nervous diseases in which there is increased abdominal tension they are diminished or lacking. Hysteria does not abolish them, even when anaesthesia of the skin of the abdomen exists. They have been used also in the localization of spinal injuries."

He calls attention to the fact that Rolleston and Sicard noted marked diminution or absence of the reflex in over ninety per cent of cases of typhoid fever. In common with other observers he finds that the reflexes are abolished or disturbed in practically all cases of general peritonitis and other acute intra-abdominal inflammation; that in acute localized inflammatory conditions the reflex is usually lost in the quadrant in which the acute process is located. Therefore the reflex has a certain diagnostic value in appendicitis and other localized conditions. In seventy-five cases of acute appendicitis the lower right quadrant was involved in sixty-five. Of the ten not involved three were children, the others Smith regards as being

exceptions to the rule. The writer states that but little importance can be attached to the presence or absence of the reflex in children since in practically all conditions the reflexes are particularly acute in the young. He states: "that the extent to which the reflex is involved is significant. An involvement of the reflex of the right lower quadrant has always denoted a fairly well localized inflammatory process. With further involvement, that is, an absence of the reflex of the upper right or lower left quadrant, the inflammation may yet be fairly well circumscribed. But when all are involved we have almost invariably found a considerable extension from the original seat of trouble. In all severe extensions of the inflammatory process, the condition commonly designated as 'general peritonitis,' all the reflexes have invariably been absent."

He states that when the general symptoms of appendicitis were definite with little or no involvement of the right lower reflex, the reason therefor was usually apparent on opening the abdomen. In such cases there was no peritonitis, and but moderate trouble in the appendix.

He also found involvement of the local reflex in a large percentage of cases of acute cholecystitis, pelvic inflammatory disease, and perforated gastric ulcer.

In twelve cases of acute obstruction of the bowel the reflexes were apparently uninvolved, the tentative conclusion being that the presence of the reflex may be an important item in the differential diagnosis of this condition.

Smith's final conclusion is: "that the abdominal cutaneous reflex has a distinct, though limited, value in acute conditions within the abdomen and that, although perhaps not as valuable a sign as rigidity (or lack of it), when combined with other symptoms, it is of value in strengthening our diagnosis."

FRACTURE OF THE NECK OF THE FEMUR.

Whitman, Royal: A Critical Analysis of the Treatment of Fracture of the Neck of the Femur. *Annals of Surgery*, Oct., 1914, Vol. LX, No. 4, p. 485.

Whitman again calls attention to the splendid results obtained in the treatment of fractures of the femoral neck by the abduction method. He points out that in these cases, whether of complete or incomplete fracture, there is practically always a coxa vara deformity, due to the upward pull on the outer fragment by the gluteus medius and minimus. He states that since many fractures of the neck of the femur are incomplete or impacted, the immediate results are satisfactory, but that the resultant traumatic coxa vara always entails disability. The abduction method always restores the normal angle of the neck with the shaft of the femur, thus preventing shortening and deformity, and by placing tension on the internal inferior portion of the capsule produces at that point an efficient fascial splint which is of great value in maintaining accurate and constant approximation of the fragments and thus is a factor in early union.

Upward displacement is prevented by the engagement of the outer fragment beneath the acetabular rim, or by contact of the trochanter with the pelvis; the attitude of abduction also prevents "displacement by muscular action since the pelvi-trochanteric group is relaxed, while contraction of the iliopsoas and abductors tend to appose, rather than separate, the fragments."

The plaster spica, being an independent splint, allows the patient any desired change of posture, does away with the necessity for prolonged recumbent immobilization and necessity for elevation of the foot of the bed, as in the traction method, with its consequent dangers of hypostatic pneumonia and other congestions, and permits movement without pain. Cases treated by the abduction plaster method are often allowed a reclining wheel chair during the second week. This method is as efficacious and as

productive of excellent results in fracture of the upper third of the femoral shaft as in fracture of the neck.

Whitman describes the application of this method as follows: "The patient, usually anaesthetized, is lifted to a pelvic support, preferably furnished with a perineal bar for counter pressure, the extended limbs being supported by assistants. The assistant holding the uninjured limb abducts it to the normal limit in order that it may serve as a guide, and incidentally to fix the pelvis. The injured limb is first flexed and rotated sufficiently to disengaged soft parts that may be interposed between fragments. It is then completely extended, and the assistant, by direct manual traction, overcomes the shortening, as demonstrated by measurement and by the relation of the trochanter to Nelaton's line, at the same time correcting the outward rotation. Still maintaining steady traction, he then abducts the limb to correspond with its fellow, the operator meanwhile supporting the joint and lifting the thigh upward. The pelvis should now be level and the extended limbs in exact correspondence in every particular. A plaster spica is then applied from the axilla to the toes. This should be carefully adjusted about the pelvis and trochanter. It should completely cover the buttock and be heavily reinforced beneath the joint and thigh, that it may be unyielding to pressure and therefore effective as a posterior splint to hold the limb in its proper plane."

HERPES ZOSTER.

Althoff, D.: Treatment of Herpes Zoster. *Therapeutic News*, July, 1914.

Herpes zoster seems to be an acute general infection, of which the pain and the vesicles along nerves is probably only a local manifestation. The general health of these patients is usually more or less disturbed. Treatment should begin early and must be both general and local. Splendid results are obtained by giving internally urotropin and aspirin 10 grains each in half

glass of water, followed by a cup of hot tea. Repeat 3 or 4 times a day. Locally thymol and carbolic acid 5 grains to vaseline one ounce makes a good impression.

DIPHTHERIA PROPHYLAXIS.

Schick, B.: The Diphtheriatoxin Skin Reaction as a Preliminary to the Prophylactic Injection of Diphtheria Antitoxin. *M. m. W.*, Nov. 25, 1913.

The object of the prophylactic injection is to remedy an absence of antibodies in an exposed individual. Investigations have shown that many individuals possess antibodies without ever having had any symptoms of diphtheria.

In the new-born the percentage is 80, in adults 90, during childhood between 50 and 60 per cent. Prophylactic injections could be dispensed with, therefore, in a large number of exposed individuals if we had a simple method by which we could ascertain the presence or absence of antibodies.

Loewenstein, Michiels, and Schick have shown that the intracutaneous injection of minimal doses of diphtheriatoxin produces a specific skin reaction, which indicates that no antibodies are present.

Technic: A small hypodermic syringe is used with a thin needle that has a short point. It is inserted into the skin with its opening upward so that it is covered soon after its insertion. The small quantity of diphtheriatoxin to be injected is 1 ccm. of a dilution prepared by diluting to 1000, the quantity of toxin required to kill a guinea pig of 250 grm. weight. The reaction that takes place simulates a tuberculin reaction. In from 4 to 8 hours is noticed an increasing redness and infiltration reaching their maximum in 48 hours. This is a positive reaction. A negative result always indicates the presence of antibodies. A positive result is not of the same value, because some individuals, adults as well as children, occasionally present a reaction despite the presence of antibodies.

The importance of this test will be apparent if we consider the great number of

negative results, *i. e.*, persons having antibodies present in their blood and therefore requiring no prophylactic injection on exposure. Repeated investigations have given us the following figures:

Newborn, 80 per cent negative.

First year, 57 per cent negative.

Two to five years, 37 per cent negative.

Five to fifteen years, 50 per cent negative.

During a prolonged exposure, as in institutions, a person who has reacted negatively, should be tested out again in about four weeks.

DIPHTHERIA PROPHYLAXIS.

Kassowitz, Karl: Contribution on the Method of Diphtheria Prophylaxis. *M. m. W.*, Sept. 15, 1914.

Injections of prophylactic doses of diphtheria serum should no longer be made indiscriminately to all persons exposed. All these should have the benefit of one or more cultural examinations. All positives should be given an intracutaneous diphtheriatoxin injection according to the method of Schick. A prophylactic diphtheria serum injection is required only by those reacting positively to Schick's toxin injection.

THE USE OF RADIUM.

Howard A. Kelly and Curtis F. Burnam: Radium in the Treatment of Uterine Hemorrhage and Fibroid Tumors. *Journal A. M. A.*, Aug. 22, 1914. Vol. LXIII, pp. 622-628.

The authors precede the report of their cases by a review, with bibliography, of the development of ray therapy as applied to the conditions mentioned.

The cases which they report themselves are 39 in number and the authors divide them into the following four groups: Group one is the so-called myopathia-hemorrhagica class. The patients are adults, suffering from marked menorrhagia or metrorrhagia, and presenting no disease of the pelvic organs except perhaps a slight enlargement of the uterus. Group two includes most of the hemorrhages occurring in young girls. Group three includes cases of so-called polypoid endometritis. The

fourth group is that of true uterine myomata.

Most of the technics previously devised for the treatment of these conditions endeavored to concentrate the maximum amount of the rays, either Roentgen-rays or rays emanating from radium, on the ovaries leaving the uterus more or less out of consideration. This technic has been based on the fact that these rays will destroy the primordial follicles of the ovary and it was hoped that the resulting sterility would have a secondary beneficial effect on the uterus.

It is well established, however, that both Roentgen and radium rays cause an obliterative endo-arteritis almost invariably in the field radiated. The authors believe that there is a specific and direct action of the rays on the uterus or fibroid itself and they believe that they can obtain this action independently of any action on the ovaries.

The technic used is filtration through glass, platinum, zinc and rubber. Such an apparatus, suitably shaped, is inserted directly into the uterine cavity. As a preliminary the patient is examined carefully under nitrous oxide anæsthesia and is curetted. The amounts used vary from 30 mg. to 560 mg. of radium element in the fibroid cases down to as low as 12 mg. in the young girl group. The time of application varies in these cases from one and one-half to forty-eight hours.

The results in these thirty-nine cases are as follows:

Group one, eight cases. All finally had a complete amenorrhea, which was the desired result. One patient required two exposures to radium, the others but one each.

Group two, five cases in young girls. Four of the patients have had normal regular periods since treatment. The fifth patient, who required a large amount of radium, has had complete amenorrhœa. But one exposure given in each case.

Group three, five cases. Amenorrhœa, the desired result, attained in four. The

fifth required subsequent hysterectomy. But one exposure in each case.

Group four, twenty-one cases. One case required subsequent hysterectomy. The others were all either entirely cured or greatly benefited. Complete amenorrhœa was obtained in sixteen cases. In eight cases the uterine tumor entirely disappeared. In twelve cases the tumors were markedly reduced in size.

As a result of these cases the authors conclude that radium offers a remarkable therapeutic agent for controlling uterine hemorrhage in the classes of cases cited. In fibroid therapy it often gives results equal to radical surgical procedures without the danger, pain, etc.

As compared with the Roentgen rays it is simpler of application, more rapid in action, and acts on the uterus with more intensity than it does on the ovaries. The authors insist that the application shall be made intra-uterine and that the fibroid itself shall receive the major radiation.

RECURRENT VOMITING.

Kerley, Charles Gilmore: One Hundred and Forty-one Cases of Recurrent Vomiting in Private Practice. *Am. Journal Diseases of Children*, Oct., 1914. Vol. VIII, p. 292.

The author refers to the fact that in his experience recurrent vomiting, in a vast majority of cases, occurs in the offspring of those who for two or more generations have not engaged in manual work but have followed professional or business occupations.

He finds this condition frequently associated with other forms of illness most notably bronchitis of a spasmodic type and recurrent colds. Not infrequently there existed a history of eczema, rheumatism, enuresis, occasionally asthma and habit tic. While relationship probably exists between recurrent vomiting and all these conditions it is of noteworthy interest that acetone in the urine was not found in any of them except where gastric symptoms existed. As a result of his observation on the effects of

certain dietetic errors the author concludes that recurrent vomiting is largely due to defective oxidation or in giving food of high carbon content in excess of the powers of normal oxidation. He regards insufficient exercise as also a factor contributing to the defective oxidation. Recurrent vomiting and related conditions are observed more frequently in winter months than in summer, since then activity is lessened and perspiration is least.

In the interval management of these cases the author restricts the use of cow's milk, except skimmed milk scantily employed, butter, cream and sugar. One egg is allowed every third day and saccharin is largely employed as a sweetening agent. Highly energized foods such as red meat, poultry and fish are given scantily. Bodily exercise, both active and passive, warm baths and attention to the bowel function are essential to successful treatment. The intermittent use of salicylate of soda and the more or less constant use of bicarbonate of soda for months or years if needed constitute the essentials of medicinal treatment. For the acute vomiting attacks bicarbonate of soda is employed by mouth and rectum and magnesia as a laxative and antacid. Forcible attempts at feeding are not advised.

THE TONSILS.

Comroe, Julius H.: The Use and Abuse of the Tonsils. *Journal A. M. A.*, Vol. LXIII, p. 1367.

The functions of the tonsils are detailed in a manner so forceful and complete as to convince the most skeptical of the value of these organs. In support of his statements the author cites numerous authorities thereby rendering his paper even more valuable than it otherwise might have proven. The lymphoid structure of the tonsils and a description of the physiology of lymphoid tissue in general furnish undeniable evidence of the protective functions of the tonsils. The mere enlargement of these organs in childhood is regarded as physiological, and since they are generators of lymphocytes and

leucocytes, which constantly exert a bactericidal action, the tonsils should be regarded as protective organs rather than as a menace to health and development.

The epithelium covering the tonsils is endowed with a special function which prevents the entrance to the interior of infectious bacteria. This defense against absorption is maintained as long as the integrity of the healthy epithelial covering of the tonsil is preserved. While infectious germs are frequently found in the tonsillar crypts of both healthy and sick individuals they probably are not causative of tonsillar inflammation since autoinfection is probably essential to follicular tonsillitis.

Other functions of the tonsils including those of internal secretion, lubrication, immunity and phonetics are referred to in convincing detail.

The author deplores the indiscriminate removal of tonsils and enumerates certain ills that not infrequently result from tonsillectomy. Three indications are mentioned justifying this operation: (1) When, owing to their increased size, they interfere with respiration and oxygenation of the blood; (2) when they are actually diseased beyond repair and (3) when they undoubtedly contribute to the production of disease.

The author concludes his able paper with the expression of his belief that the tonsils were designed for good and not evil, and that normal tonsils have physiologic, chemical and phonetic functions and should not be indiscriminately removed.

SPOROTRICHOSIS.

Sutton, Richard L.: Sporotrichosis in the Mississippi Basin. *Journal A. M. A.*, Vol. LXIII, p. 1153.

In an article with six good illustrations Sutton calls attention to the fact that of the fifty-four cases of Sporotrichosis reported in this country, all of the patients resided in the so-called Mississippi River Basin. Owing to the fact that the disease is not often recognized by the profession, Sutton concludes that cutaneous Sporotrichosis is a

comparatively common disorder in the middle west. In every suspected case a bacteriologic test should be made as early as possible, otherwise the employment of antiseptics may render the culture examinations negative. Familiarity with the characteristic symptoms of the infection make a mistake in diagnosis unlikely. The treatment used in the five cases reported by Sutton was local antiseptic dressing, and the internal administration of potassium iodid in increasing doses, the result was good in all of the cases.

SYPHILIS IN COLORED CANAL LABORERS.

Baetz, Walter G.: Syphilis in the Colored Canal Laborers. *New York Medical Journal*, Vol. C, p. 820.

A resume of 500 consecutive medical cases of syphilis in the negro in the medical wards of the Canal Zone hospital is the basis of a very interesting article by Baetz. Attention is called to the absence of tabes dorsalis, and the rarity of paresis. The author mentions the fact that lesions of the mucus membrane are not common among the negroes of the Canal Zone, that syphilis is a very common disease; 6 per cent of the hospital admissions being recognized syphilitics.

TRICHLORACETIC ACID TREATMENT OF LUPUS.

Heidingsfeld, M. L.: A New Method of Treatment of Lupus Vulgaris. *Journal of the A. M. A.*, Vol. LXIII, p. 1352.

Heidingsfeld reports the results of treatment of 12 cases of Lupus Vulgaris with the local application of a saturated solution of trichloroacetic acid to the Lupus nodules. The author claims that the caustic has a selected action for the nodules; pain being slight when the application was followed by a soothing sulphur lotion. Good cosmetic results were obtained and the treatment was prompt in its effect and a number of cases proceeded to complete clinical recovery. The article is well illustrated with nine photographic cuts.

COMPARISON OF RADIUM AND X-RAY IN THE TREATMENT OF SKIN DISEASES AND CANCERS.

Simpson, C. Augustus: The Relative Value of Radium and X-Ray in Treatment of Skin Diseases and Cancer. Southern Medical Journal, Vol. VII, p. 815.

The writer in an article of several pages gives his experience, and quotations from the reports of prominent and experienced Dermatologists and Roentgenologists to the fact that with the proper use of X-ray a general superiority is had over that of Radium in the treatment of cutaneous lesions. The massive dose is advocated and claim is made that this exposure properly measured and properly filtered of the Alpha and Beta rays is as effective as the exposures of large amounts of Radium.

DIFFERENTIAL LEUCOCYTE COUNT.

Miller, S. R., M. D., The Normal Differential Leucocyte Count, Johns Hopkins Hospital Bulletin, No. 284, p. 317.

Miller gives the following table of the normal differential leucocyte count by various authors and calls attention to the wide gap between the figures of Ehrlich and Bunting:

Author.	N.	E.	B.			
	M.	M.	M.	M.	M.	
	P.	P.	P.	S.	L.	T.
1. Pappenheim ..	70-75	2-4	0-1	20-22	2	6
2. Turck-Sahli ..	70-75	2-4	1-5	22-25	1	1-4
3. Emerson—						
Ehrlich	70-72	2-4	.5	22-25	1	1-4
4. Morawitz	65-75	2-4	.5	20	5	7
5. Webster	65-75	2-4	.5	20-25	3	5
6. Wood	65-75	2-4	.5	22-25	1	2-4
7. Krause	65-70	2-3	.5	22-25	3	5
8. Naegeli	65-70	2-4	.5	22-25	3	5
9. Brugsch and S.	65-70	2-4	.5	20-25	3	5
10. Morris	65-70	2-4	.5	22-25	3	5
11. Cabot	60-70	.5-4	1-5	20-40	1	10
12. Simon	60-70	1-4	2-1	20-30	1	6
13. Bunting	50-60	.8-4	4-1.8	30-40	.6-2	6-8

The different stains used are mentioned as the probable cause in the difference in classification. The stains, however, are not thought to give variations sufficient to account for the difference in percentages. Miller gives a set of figures based on the count made on a set of one hundred selected smears prepared by fifty students. The smears were prepared by the students from

their own blood as a part of their course in Clinical Microscopy. Differential count was made on each of these one hundred smears in which two hundred and fifty leucocytes were counted in each smear and a large number of other counts was made bringing the total up to six hundred and fifty. The average percentage values of the leucocytes in normal blood are given as follows for the six hundred and fifty counts:

Polymorphonuclear	64.2%
Eosinophile	2.7%
Basophile .....	.6%
Small Mononuclear	22.2%
Large Mononuclear	8.0%
Transitional	2.8%

The average for the different cells vary from forty to eighty per cent for polymorphonuclears with three hundred and sixty-two counts varying between sixty and seventy per cent. The small mononuclears vary from less than ten to more than thirty with two hundred and forty-three counts, showing a variation of twenty to twenty-five per cent. The large mononuclears vary from less than five to more than fifteen with three hundred and fifty-nine counts with a variation of five to ten per cent. The transitionals vary from zero to more than four per cent with four hundred and thirteen counts between two and four per cent.

The conclusions drawn by the author on this series of counts are as follows:

- "1. The total leucocyte count and differential formula in normal individuals are subject to relatively wide variations, which must be considered in the interpretation of studies made upon the bloods of individuals presumably suffering from abnormal conditions.
- 2. The interpretation of any differential count should be based upon:
 - (a) A knowledge of that particular individual's normal blood picture, when possible.
 - (b) The average values for the locality in which that individual resides.
 - (c) A consideration of those factors peculiar to the individual which might modify that particular blood.

3. Differential leucocyte counts should always be reported in terms both of percentage and absolute numbers per cubic millimeter, and in all cases, where possible, more than one differential count should be made, especially in borderline cases in which slight changes are to be regarded as of diagnostic or prognostic value.

4. The tendency to ascribe a diagnostic value to lymphocytosis is probably overdone. Only when the mononuclear elements constantly exceed the average percentage, absolute values and upper limits of variation (35-40 per cent) for the community and when all modifying factors are considered, should one attempt to draw valuable conclusions from the figures obtained."

VAGINITIS.

Sharpe, W. B.: *The Bacteriology of Vaginitis*, *The Journal of Infectious Diseases*, Vol. XV, No. 2, p. 283.

Sharpe states that vaginitis is often considered of gonorrhoeal nature on account of its clinical resemblance to the disease. Stained smears sometimes show gonococci but often a number of diplococci which are neither typical morphologically nor intracellular. The object of the paper is to determine the true etiology of the condition.

Cultured slides of fifteen cases show the presence of gonococci, staphylococci, colon bacilli and a strain of pseudo-diphtheria. This strain of pseudo-diphtheria was found to be gram positive and pleomorphic. From one of the fifteen cases studied staphylococci, colon bacilli and pseudo-diphtheria were isolated. Aerobic bacteria predominate in pathogenic vaginas while anaerobic bacteria predominate in the normal. Gonococci are often found after the cessation of the discharge and may be responsible for the recurrence, so frequently observed. Twenty-six unselected cases showed one or more recurrences at intervals of three weeks to six years and it seems that latent infection is a probable factor.

In order to determine whether the gonococcus had existed, gonococcus toxin was used after the method described by Irons.¹ "Glycerine extract of gonococcal protein introduced on a needle point at two places in the skin, caused zones of hyperemia, which was not produced by two control punctures." Where these zones measured five millimeters and assumed a papular appearance the case was considered positive; a zone from two to four millimeters doubtful, and less than two negative.

The complement fixation test depends on whether the immunity is high or low and the results follow closely those of the skin test. The cases giving a doubtful or negative skin test do not give complement fixation. The production of immunity is a variable factor and not in relation to the amount of discharge. "A negative complement fixation test of the patient's serum has been regarded as evidence of a cure of vaginitis." (Smith.²) The work in this article, however, indicates that a negative complement fixation could not be levied upon as indicating a cure since gonococci have been isolated from such cases.

Out of twenty-seven cases studied the gonococcus was isolated from twenty-two cases, complement fixation was positive in nine and gonococcus toxin skin test was positive in ten, and direct examination of smears gave five positive. It seems from the analysis of these that most of the cases of vaginitis were gonorrhoeal and the organisms persisted as long as the discharge.

The secondary invader is either not easily cultivated aerobically or is a normal inhabitant of the vagina. Sharpe found the cutaneous test more delicate than the complement fixation test, but he found that laboratory

¹Treons, E. E.: *Cutaneous Allergy in Gonococcal Infections*, *The Journal of Infectious Diseases*, Vol. XI, No. 1, p. 77.

²Smith, G. G.: *Complement Fixation Test in Management of Gonococcus Vulvovaginitis*, *American Journal of Diseases of Children*, Vol. V, No. 4, p. 313.

tests are of little value in determining the presence of the gonococcus in these cases.

NEWS ITEMS.

Dr. James H. Randolph, of Jacksonville, visited the state asylum in Chattahoochee during the past month.

The many friends of Dr. W. S. Grambling will regret to learn that he has been seriously ill.

Dr. Iva C. Yeomans, for many years connected with the State Board of Health, has been placed in charge of the new branch laboratory recently opened in Miami.

Dr. A. J. P. Julian, of Lake City, was a visitor in Jacksonville during the past month.

Drs. R. H. McGinnis and P. C. Perry were in Richmond in attendance at the annual meeting of the Southern Medical Association.

Dr. Joseph Y. Porter, State Health Officer, spent a part of October in Key West.

NEW AND NON-OFFICIAL REMEDIES.

Since publication of New and Non-official Remedies, 1914, and of the supplement to New and Nonofficial Remedies, 1914 (July 1, 1914), the following articles have been accepted for inclusion with "N. N. R." Arlington Chemical Co.:

Arleo Urease.

The Bayer Company, Ind.:

Cymarin, Tablets Cymarin, Ampules Cymarin Solution.

Fougera and Co.:

Electrargol for Injection, 10 cc. Ampules.

Hyson, Wescott and Co.:

Urease-Dunning.

Maltine Co.:

Maltine Malt Soup Extract.

H. K. Mulford Co.:

Hypodermic Tablets of Emetine Hydrochloride; Antidysenteric Serum in vials containing 50 cc.; Antipneumococcic Serum, Polyvalent, syringes containing 20 cc., and vials containing 50 cc.; Anti-

streptococcis Serum, Polyvalent, vials containing 50 cc.; Antistreptococcic Serum, Scarlatinal, Polyvalent, vials containing 50 cc.; Typho-Serobacterin Mulford, Immunizing, syringes containing 1,000, 2,000 and 2,000 million killed sensitized typhoid bacilli.

Schiffelin and Co.:

Typhoid Combined Vaccine (Prophylactic), vials and syringes containing three doses, 500 million killed typhoid bacilli and 250 million killed paratyphoid bacilli A and 250 million killed paratyphoid bacilli B, while the second and third dose each contain 1,000 million killed typhoid bacilli and 500 million each of killed paratyphoid bacilli A and B.

E. R. Squibb and Sons:

Acne Vaccine, boxes of 4 syringes containing 25, 50, 100 and 200 million killed bacilli, boxes of 2 syringes containing 50 and 200 million killed bacilli, boxes of 6 ampoules containing 10, 25, 50, 100, 200 and 500 million killed bacilli, with syringes, and boxes of 3 ampoules containing 50 and 200 million killed bacilli with a syringe. Bacillus Coli Communis Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli. Also boxes of 2 syringes containing 100 and 500 million killed bacilli and boxes of 2 ampoules containing 100 and 500 million killed bacilli, with a syringe. Bacillus Pertussis Vaccine, boxes of 4 syringes containing 25, 50, 100 and 200 million killed bacilli. Also boxes of 2 syringes containing 50 and 200 million killed bacilli. Boxes of 6 ampoules containing 25, 50, 100, 200, 300 and 500 million killed bacilli, with a syringe, and boxes of 2 ampoules containing 50 and 200 million killed bacilli, with a syringe. Diphtheria Antitoxin, syringes containing 2,000, 3,000, 4,000, 5,000, 7,500, and 10,000 units. Gonococcus Vaccine, 4 syringes containing 100, 200, 350 and 500 million killed gonococci, boxes of 2 syringes containing 100 and 500 million

killed gonococci. Boxes of 6 ampules containing 50, 100, 150, 350, 500 and 1,000 million killed gonococci, with a syringe and boxes of 2 ampules containing 100 and 500 million killed gonococci, with a syringe. Meningococcus Vaccine, Curative, boxes of 4 syringes containing 100, 200, 400 and 500 million killed meningococci. Also boxes of 2 syringes containing 100 and 500 million killed meningococci. Boxes of 6 ampules containing 100, 100, 500, 500, 1,000 and 1,000 million killed meningococci, with a syringe, and boxes of 2 ampules containing 100 and 500 million killed meningococci, with a syringe. Meningococcus Vaccine, Immunizing, boxes of 3 syringes containing 100, 500 and 1,000 million killed meningococci. Pneumococcus Vaccine, boxes of 4 syringes containing respectively 100, 200, 400 and 500 million killed pneumococci, boxes of 2 syringes containing respectively 100 and 500 million killed pneumococci, boxes of 6 ampules containing 10, 100, 500, 500, 1,000 and 1,000 million killed pneumococci, with a syringe, and boxes of 2 ampules containing 100 and 500 million killed pneumococci, with a syringe. Pyocyaneus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli. Also in boxes of 2 syringes containing 100 and 500 million killed bacilli. Smallpox (Variola) Vaccine (Glycerinated), each dose in separate aseptic sealed glass tube, with bulb and needles. Boxes of 5 and 10 tubes. Staphylo-Acne Vaccine, boxes of 4 syringes containing 100 million killed staphylococci and 25 million killed acne bacilli, 200 million killed staphylococci and 50 million killed acne bacilli, 400 million killed staphylococci and 100 million killed acne bacilli, and 500 million killed staphylococci and 200 million killed acne bacilli; boxes of 2 syringes containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million

killed staphylococci and 200 million killed acne bacilli, boxes of 2 ampules containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million killed staphylococci and 200 million killed acne bacilli with a syringe. Staphylococcus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed staphylococci. Also boxes of 2 syringes containing 100 and 500 million killed staphylococci. Boxes containing 6 ampules containing 100, 250, 500, 500, 1,000 and 2,000 million killed staphylococci, with a syringe, and boxes of 2 ampules containing 100 and 500 million killed staphylococci with a syringe. Streptococcus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed streptococci. Also boxes of 2 syringes containing 100 and 500 million killed streptococci. Boxes of 2 ampules containing 100 and 500 million killed streptococci, with a syringe. Typhoid Vaccine, Curative, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli. Also boxes of 2 syringes containing 100 and 500 million killed bacilli. Boxes of 6 ampules containing 200, 200, 500, 500, 1,000 and 1,000 million killed bacilli, with a syringe and boxes of 2 ampules containing 100 and 500 million killed bacilli, with a syringe. Typhoid Vaccine, Immunizing, boxes of 3 syringes containing 500, 1,000 and 1,000 million killed bacilli.

Waukesha Health Products Co.:

Hepco Flour, Hepco Dodgers, Hepco Grits.

H. M. Alexander & Co.:

Normal Horse Serum; Typhoid Vaccine, Immunizing.

Comar & Cie:

Electrargol; Electrargol for Injections 10 cc. Ampoules.

Farbwerke Hoechst Co.:

Amphotropin; Erepton.

Fairchild Bros. and Foster:

Trypsin.

Franco-American Ferment Co.:

Lactobacilline Tablets; Lactobacilline Liquide, Culture A; Lactobacilline Liquide, Culture D; Lactobacilline Liquide, Infant Culture; Lactobacilline Glycogene Liquide; Lactobacilline Milk Glycogene Liquids; Lactobacilline Milk Tablets; Lactobacilline Milk Ferment; Lactobacilline Suspension.

Hoffman-LaRoche Chemical Works:

Thiocol; Syrup Thiocol, Roche; Thiocol Tablets.

Hynson, Westcott & Co.:

Phenolsulphonephthalein, H. W. and Co.; Phenolsulphonephthalein Ampules, H. W. and Co.; Urease-Dunning.

Merck and Co.:

Cerolin.

H. K. Mulford Co.:

Acne Serobacterin; Anti-Anthrax Serum, Mulford; Antistreptococcus Serum Scarlatina, Mulford; Coli Serobacterin; Culture of Bulgarian Bacillus, Mulford; Disinfectant Krelon, Mulford; Neisser Serobacterin; Pneumo Serobacterin; Salicylos; Scarlatina Strepto Serobacterin; Staphylo-Serobacterin; Staphylo Acne Serobacterin; Strepto Serobacterin; Typho Serobacterin.

Riedel & Co.:

New Bornyval.

Reinschild Chemical Co.:

Phenolphthalein Agar.

E. R. Squibb & Sons:

Sodium Biphosphate, Squibb; Tetanus Antitoxin, Squibb; Tetanus Antitoxin, Squibb, 5,000 Units.

Hoffmann-LaRoche Chemical Works:

Digalen:

The Council has voted that the acceptance of Digalen and Digalen Tablets be rescinded and that these products be omitted from New and Nonofficial Remedies. A report explaining this action has been authorized for publication.

Antiseptic Supply Co.:

Stypstick Applicators, Alum 75 per cent.

Hynson, Westcott and Co.:

Urease-Dunning.

Waukesha Health Products Co.:

Hepco Flour.

Hepco Dodgers.

Hepco Grits.

E. Fougere and Co.:

Electrargol:

At the request of the manufacturer—Comar and Co., Paris—the Council has recognized E. Fougere and Co., New York, as the American selling agents for the product. Also in view of information received from Comar and Co. it has modified the New and Nonofficial Remedies description for Electrargol to indicate that this product now contains the equivalent of .4 per cent. of metallic silver.

HEPCO FLOUR.—A flour prepared from the Soya bean. It is claimed that clinical trial has shown that the small percentage of carbohydrates in Hepco Flour is in the main not sugar-producing, and that it therefore is a suitable food material in cases in which carbohydrates are contraindicated, as in diabetes, amylaceous dyspepsia, etc. Hepco Flour is also sold in the form of biscuits as Hepco Dodgers and a granulated "break-fast food" as Hepco Grits. Waukesha Health Products Company, Waukesha, Wis. (*Jour. A. M. A.*, September 26, 1914, p. 1113.)

THE TREATMENT OF THE OPIUM HABIT.—A great many narcotic habits owe their start in the habit to the careless, or even criminal manner in which some physicians prescribe or dispense habit-forming drugs. It is a good plan to purchase your supply of these drugs and dispense them as necessary without giving the patient any information as to their nature.

When the habit is once formed many of the unfortunates would be willing to make any sacrifice to be cured of the disease, for such it is, but they are looked upon as pariahs to be shunned, so that they soon lose heart in the struggle, give up in despair and gradually sink lower and lower until death steps in to end the scene. These unfortunates lack the strength to endure the terrible suffering entailed by their attempts to do without their usual dose of the drug.—Melville A. Hays, M. D., in *New York Medical Journal*.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, December, 1914

Number 6

ORIGINAL ARTICLES

ACUTE INFLAMMATION OF THE PELVIC ORGANS.*

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Acute pelvic inflammation of any degree of severity is not, as a rule, confined to any one organ or set of organs, but involves more or less extensively all the female pelvic organs.

For example an acute gonorrhoeal endometritis may at first give symptoms referable only to the uterus. If the process becomes at all severe there is, in addition to the endometritis, a more or less extensive infection of the tubes. While the symptoms in given cases may be referable to the uterus alone, on account of the widespread distribution of the infection the case should be regarded as one of general pelvic inflammatory disease. By such consideration our therapeutic measures will be more effective and less likely to be a source of actual danger to our patients.

Two principal types of pelvic infection may be recognized from the pathological standpoint. In the ordinary type the infection travels by continuity along the uterine mucosa to the tubes and out through the tubes to the pelvic peritoneum and ovaries. This is the ordinary gonorrhoeal type of pelvic inflammatory disease. While all the pelvic organs are more or less involved, the process is most marked in the tubes and the pelvic peritoneum adjacent.

The second and more infrequent type is the true pelvic cellulitis. Here the infection is usually more virulent. It travels by

the lymphatic channels through the walls of the uterus, setting up an actual metritis, to the cellular tissue around the uterus in the broad ligament. Such infections are more frequent after infected labors and abortions. The organisms present are often streptococci or staphylococci. Tubal involvement is secondary and usually of not so great importance as in the first type. Abscess formation, septic phlebitis and general sepsis are the more frequent occurrences in the severe types of this form of infection.

While this second type is usually seen after dirty labors or abortions it by no means follows that all puerperal sepsis is of this type. Actually many puerperal infections are gonorrhoeal in character, coming from a pre-existing gonorrhoeal endometritis and not from sepsis introduced at labor. In such instances the infection is of the ordinary gonorrhoeal type.

A word as to the involvement of the ovary in pelvic inflammation. While there is usually some involvement of the ovaries in acute inflammation of both the types mentioned this is not so important as the infection in either the tubes or the cellular tissue. On account of its position the ovary can only be involved when the pelvic peritonitis has extended from the tube to the ovary. The most frequent involvement is a periophoritis, or inflammation about the ovary. Occasionally we do have general inflammation of the ovarian substance or abscess formation in the depths of the ovary. In many cases of actual ovarian abscess we are really dealing with a small ovarian cyst which has become infected.

While these two types of pelvic inflammation are of practical interest in the prog-

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

nosis and, to some extent, in the question of operative procedure, they are not of so much moment in considering the immediate treatment of acute inflammations. Therefore no distinction will be made between them in discussing general principles of treatment.

It is unnecessary for me to dwell at any length before this audience on the symptoms and diagnosis of acute pelvic inflammatory disease. As a rule the symptoms are characteristic and the diagnosis is easy. I would remark, however, on the necessity for always ruling out this condition before giving any other diagnosis in acute inflammatory conditions in the lower female abdomen. A careful bimanual pelvic examination should always be made in such cases even though the physician feels that in this particular patient the existence of such a lesion is impossible.

By omitting such an examination many pelvic inflammatory cases masquerade as appendicitis, gastritis, peritonitis, inflammation of the bowels, etc., etc. Careful pelvic examination in such cases would clear up the diagnosis.

From the clinical standpoint acute pelvic inflammatory disease presents two important characteristics which have a marked bearing on treatment.

First, the natural tendency of these processes to become self-limited; second, the frequent relapses which may subsequently take place after an original spontaneous "cure" has occurred.

The first phenomenon arises because such processes tend, through adhesions and the dependant position of the pelvis, to become well walled off from the general abdominal cavity. Also the gonococcus is not a very virulent or resistant organism and may be overcome by the natural bodily resistance. Inasmuch as after the subsidence of the symptoms a chronic inflammatory condition is usually left, an acute inflammation may easily be started again from one cause or another and we have the relapses which I have just mentioned.

The treatment of acute pelvic inflammatory disease presents, I think, one of the best arguments for the existence of the gynecologist as separate and distinct from the general surgeon. I do not mean to say, of course, that one man can not at the same time be a good gynecologist and a good general surgeon. But I do mean that when such a man approaches gynecological problems he must handle them from the gynecological standpoint, and that standpoint is not necessarily that of the general surgeon.

For example, let us compare the proper treatment of an acute suppurative appendicitis with that of an acute pelvic inflammation. There is practically no doubt as to the good surgeon's position in the appendicitis. Other conditions being propitious, an operation as soon as the diagnosis is made would be the dictum. Let him, however, handle his pelvic inflammatory cases along the same lines and not only would he unnecessarily sacrifice organs which under different treatment he might save, but he would also cause the death of a certain number of women whose lives might have been spared had he used the principles of gynecology instead of those of general surgery.

The proper treatment for acute pelvic inflammation is based on the fact noted above, that the majority of such inflammations, under proper conditions, are self-limited and that as a rule the acute process will spontaneously subside, leaving a condition of chronic inflammation which can be dealt with as may be indicated. Then and then only should operation be performed.

"But," says the operator who views gynecological problems solely from the standpoint of the general surgeon, "why wait all this time before operation? If, as is probable in severe cases, the patient will need operation anyway, why not do it at first and get your patient well as soon as possible?"

There are two reasons. First, radical operation with removal of diseased parts is often attended with great danger when done during the height of an attack, and is always more severe than when done after the process has reached the quiescent stage; second, by waiting until the acute stage has passed we are often able to save organs which would have been sacrificed had the operation been done earlier.

I wish to quote from a paper which I read at Ocala six years ago a table showing the main differences between appendix surgery and that of pelvic inflammatory disease.

	Appendicitis.	Pelvic Inflammatory Disease.
Anatomy	Supplied by terminal artery. Inflammation less likely to subside spontaneously. Gangrene ensues from obstruction to artery.	Rich blood supply therefore inflammation more apt to subside. Gangrene never occurs.
Physiology	No known value of organ.	Organs of greatest value, both to patient and to society.
Bacteriology ..	Extremely virulent organisms often present.	Extremely virulent organisms rarely present.
Extent of operation	The operation not severe in itself, considering gravity of lesion in individual cases. Operation <i>per se</i> is rarely fatal.	Radical operation is always extensive and severe. Attended with great shock and often fatal <i>per se</i> .
Course of disease if no operation is done.	General or localized peritonitis with subsequent death is frequent.	General peritonitis is rare. Usually recover from an acute attack when proper treatment can be used.

The treatment which gives the best results in these acute cases is simple.

The most essential and important feature is absolute rest in bed. The use of the bedpan is necessary, the patient must get out of bed on no pretext whatsoever. Diet should be light and bowels kept freely moved. Hot vaginal douches are of apparently some value. The ice-bag over the lower abdomen may be of some value in resolving the inflammation and it certainly is often very effectual in relieving pain. Much discomfort may be avoided by keeping the

bowels free from gas. Turpentine enemata and turpentine stupes over the lower abdomen are of use when there is much distention. When peritonitis is present the Fowler position should be employed.

Personally I use tampons and all other local medication very rarely. All intrauterine procedures, either in swabbing the uterine cavity out with antiseptics or attempts at curettage are absolutely contraindicated. They usually do more harm than good.

For the relief of pain an anodyne may be occasionally necessary. When morphine is needed I see no great harm in giving it. When much morphia is used it usually means poor nursing. A good nurse by skillful use of enemata, the rectal tube, ice bags and turpentine stupes can usually run a patient through the period of pain and tenderness with very few doses of morphia.

The nursing is a very great factor in the treatment of these patients. After a few days the pain is usually much less and then the patient becomes intolerant of the rest treatment. If the nurse is not firm it may happen that the patient will in a few hours put back the course of treatment many days. As a matter of fact these patients do infinitely better under the strict discipline of a good hospital than they do at their homes, even under the care of an excellent nurse.

When such a course of treatment is carefully carried out we find that in most cases the fever disappears in from five to ten days. The tenderness lessens and finally vanishes about the same time as the fever does. Decrease in the size of the pelvic masses takes place more slowly. Some decrease may be noted at the end of a week or ten days. It is usually marked, however, at the end of two or four weeks. The improvement which takes place in these hard pelvic masses is often astounding. A pelvis which, at the onset of treatment, was filled with a dense, brawny, tender mass, in which no individual organs could be outlined, will after three or four weeks' treatment show a uterus fairly freely movable, with small ad-

herent masses, the tubes and ovaries, on each side.

Operation, as I have said, should be postponed until the acute stage has passed. Just how long a period should elapse between the disappearance of fever and pain and the operation is a mooted question. Of course it varies with the individual cases. As a general rule I should prefer to allow an interval of from four to six weeks. Practically it is often hard to wait so long, especially if the patient is free from pain and feels well in every way.

While not every case of acute pelvic inflammatory disease requires laparotomy after subsidence of the acute trouble, at the same time I do believe that it is advisable in the majority of the more severe cases. The extent of the operation depends on the condition found. Those organs which are so diseased that apparently they can not be restored to normal should be removed, and everything else left. Total removal of the female pelvic organs without due cause is a surgical crime.

The palliative treatment of acute pelvic inflammatory disease which has thus been outlined is a general treatment, appropriate, I believe, to the greater number of these cases. All rules have their exceptions, however, and we occasionally see acute cases in which immediate operation is necessary.

Whenever infected placental remnants are present in the uterus they should be removed. This should be done as gently as possible and a thorough curettage of the uterine cavity is not indicated. Curettage in all these cases can not be too strongly condemned. Its usual result is to make the condition much worse than it was before.

The formation of abscesses occasionally makes an operation necessary during the acute stage. These abscesses are usually a secondary infection of colon bacillus from the rectum or from the appendix, which may have become adherent to the mass on the right. Transmitted inflammation to the

appendix may also cause an actual acute appendicitis.

Abscesses may form in the perimetrial cellular tissue and point behind the cervix. In such instances they should be incised through the posterior vaginal vault. Pus tubes, secondarily infected with colon bacilli, sometimes form large abscesses pointing behind the cervix. These should be opened in the same way.

Diagnosis of these abscesses in the lower part of the pelvis is easily made on examination. Colon bacillus abscesses lying in the upper part of the pelvis, often between the coils of intestine, are less easily recognized. Whenever a case does not yield to palliative treatment in the ordinary manner, when the pain and fever persist in spite of all treatment, then the presumptive diagnosis of a colon bacillus abscess is justified and laparotomy is indicated.

In these abscesses which lie in the upper part of the pelvis and do not point in Douglas' cul-de-sac laparotomy is the operation of choice. It is far safer than blindly groping through a vaginal section. The laparotomy must, however, be done with due regard to the condition of the patient and the exigencies of the case. These patients do not stand operation well. The operator should beware lest his surgical enthusiasm tempt him to procedures too extensive for his patient's strength.

General peritonitis occasionally requires immediate operation. This is more frequently the case in those processes which start from septic abortions or labors. While general peritonitis of gonorrhoeal origin does occur it is comparatively rare.

Summary.

The more important points which this paper endeavors to bring out may be summarized as follows:

1. Acute pelvic inflammation should be considered as a more or less general involvement of the entire pelvic organs.
2. Surgical principles on which treatment of acute inflammations of the general

abdominal cavity depend do not apply in acute inflammations of the pelvic organs.

2. Surgical principles on which treatment of acute inflammations of the general abdominal cavity depend do not apply in acute inflammations of the pelvic organs.

3. Palliative, non-operative treatment during the acute stage, followed if necessary by operation when the condition has subsided, will give the best results in the great majority of cases.

4. Occasionally operation may be indicated in the acute stage on account of retained secundines, or secondary infection due to the colon bacillus.

PATHOLOGICAL VAGINAL DISCHARGES.*

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In examining over a thousand women in my hospital and private work two facts have forcibly impressed themselves upon my mind. First, that very few women recognize that they have a vaginal discharge unless it is sufficient in amount to stain the clothing and, second, that a great many physicians tell their women patients that a certain amount of vaginal discharge is normal even though it be purulent.

The object of this paper is to impress very forcibly upon our minds that we should consider all vaginal discharges, other than normal menstruation, normal lochia, and the mucous discharges coincident with pregnancy, as pathological and treat them as such.

In presenting this paper I shall endeavor to touch upon the salient features in the etiology, diagnosis, and treatment of these discharges, giving most of my attention, however, to the consideration of leucorrhoea.

Few patients mention leucorrhoea as a

symptom even upon direct questioning and it is not uncommon to get as a reply to such a question that she doesn't believe that she has any more than is common to all women and has had it as long as she can remember. Another common answer is: "I have had it ever since I was married like all women."

A peculiar feature about all vaginal discharges is that they are treated both with a great deal of respect and considerable awe by the laity. Superstitions concerning them are rife. Physiological suppression of the menses due to poor physical condition will frighten a woman far more than a serious flooding. An acute gonorrhoea will often be overlooked by the patient because she believes the discharge to be normal and this is especially true of the gonorrhoea which comes on early in married life. It is rare to find a woman who can give her exact menstrual dates and still more uncommon to find one that can give the duration of a leucorrhoea.

When a patient seeks treatment for a leucorrhoea, unless she goes to see a specialist, she is more often than not given a prescription for a douche without even having been examined. This is particularly dangerous at the menopause because many cancers are thus overlooked that might have been treated and cured. In this same manner, too, chronic gonorrhoea is overlooked only to appear later as a pelvic inflammatory disease, after labor. To attempt to treat any vaginal discharge without a thorough examination is little short of criminal. Often the patient is examined but the discharge is not examined microscopically and again chronic gonorrhoea is missed. It is almost a safe rule to suspect gonorrhoea as the basis for all leucorrhoea until it has been eliminated by microscopy.

Thousands of patients a year are curetted for leucorrhoea with the diagnosis of endometritis. Such treatment not only aggravates the condition but is dangerous because an otherwise clean uterine cavity becomes infected. Endometritis *per se* is without

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

doubt one of the rarest diseases that the gynecologist has to deal with.

The causes of purulent vaginal discharges may be enumerated, from above downward, as infection resulting in pyosalpinx, pyometra, endocervicitis, cervicitis, vaginitis, and vulvitis. Although I have enumerated them from above downward the usual course of such infection is from below upward and most frequently the origin of the infection is at the midpoint, namely the cervix, and here we find the seat of the trouble most frequently.

The normal vagina is clean and moistened with a very thin mucous secretion which is acid in reaction. Doderlein considers the vaginal bacillus which bears his name to be the only normal inhabitant of the vagina; and it is a well known fact that under normal conditions no bacteria are found in the uterus and tubes. Personally, I have found in repeated examinations of slides made from the secretions from virgin and apparently uncontaminated vaginae, many forms of non-pathogenic bacteria, almost always a gram positive diplococcus, and not at all uncommonly the streptothrix and leptothrix.

In cases of leucorrhoea microscopical examination shows that bacilli predominate although the gram positive diplococcus is almost universally present as is also a gram negative extracellular diplococcus, the staphylococcus, and always when the infection is of gonorrhoeal origin the gram negative diplococcus of Neisser.

But as we are chiefly concerned in the diagnosis and treatment of these conditions and because this paper is antedated by a much more comprehensive paper on the bacteriology of leucorrhoea I will merely mention these bacteria as the more common ones and for an admirable study of the bacteriology of leucorrhoea will refer you to a recent article by Curtis.¹

The first step in the treatment of leucorrhoea is a thorough and exhaustive examination of the patient to determine the seat of the trouble and the causative factor and a further bacteriological examination of the discharge to determine the bacteriological factor. A careful history with special reference to the beginning of the trouble, the increase or decrease of the discharge; at the menstrual epoch; following coitus, and attacks of intra-abdominal and pelvic pain; and the general physical condition of the patient is indispensable.

Leucorrhoea in the virgin is not uncommon. When met we at once consider as causative factors, filth, debility, acute contagious diseases, masturbation, erosion of the cervix, polypi, and rarely hyperplastic endometritis, tumor and cancer. By exclusion the diagnosis is made and the condition treated according to the indications.

Filth will be apparent from an examination. We find the vulva reddened from irritative inflammation, collections of smegma in every fold of the mucosa, and not infrequently herpetic ulcers and verrucae. The treatment in such cases is essentially cleanliness in combination with slightly astringent douches. In this connection it is well to say that patients should always be advised to boil their douche nozzles before and after each douche.

After prolonged attacks of wasting fevers such as typhoid, and during the course of acute contagious exanthemata, especially scarlet fever, we frequently meet with a vaginitis in which the organism is, most commonly, a gram negative diplococcus and the condition is frequently mistaken for gonorrhoea. It differs from the latter in that the organisms are extracellular as a rule, though some authorities claim that they may be found intracellular in some cases, and that a cure is easily effected as a rule, by building up the general health of the patient and using a saline or boric acid douche.

¹Curtis, Arthur H., On the Etiology and Bacteriology of Leucorrhoea, Surgery, Gynecology and Obstetrics, March, 1914, Vol. XVIII, p. 299.

Aside from scarlet fever, probably the most common cause of leucorrhoea in the virgin, is erosion of the cervix. This condition is a congenital one and is due to a proliferative development of the columnar epithelium of the cervical canal, covering the portio vaginalis to a greater or less extent. As this portion is usually covered by stratified squamous epithelium it will be readily recognized when eroded by its reddened and boggy appearance. This type of erosion was first described by Fischel, who designated it as congenital ectropion and stated that he had observed it in ten out of twenty-eight uteri of young persons whom he had examined. When present it causes a hypersecretion of mucous from the cervix and gives rise to a clear mucous vaginal discharge with a very acid reaction. The discharge is not only inimical to the life of the spermatazoa but also causes more or less discomfort, producing pruritis in some cases and leading to masturbation, scratching, and douching which are the means of introducing infecting organisms and causing leucorrhoea. For this condition, there is, to my mind, but one cure and that is the amputation of the eroded portion.

Curtis, in his paper, has conclusively shown that in the majority of instances, in leucorrhoeas, the discharge originates outside of the uterus. I would further add that in the majority of instances it originates at the cervix. This is especially true in parous women for they usually have a larger or smaller laceration of the cervix, the granulation tissue of which is always chronically infected.

From married women you most commonly get the history that they first noticed the "whites" after the birth of their first baby. Quite often you get a history of first noticing them soon after marriage. In all such cases suspect gonorrhoea and never fail to rule out the gonococcus as a cause in all leucorrhoeas in women who have had sexual intercourse.

Leucorrhoea in married women and especially in parous women is so common as to be almost universal. Its causes are, in order of frequency, lacerations, gonorrhoea, misplacements, salpingitis and new growths.

In examining such patients I put them in the dorsal lithotomy position, exposed to a good light. First note the condition of the vulva and urethra and then ask them to bear down. The resultant presence or absence of rolling out of the anterior and posterior vaginal walls at once determines the extent of laceration. I then take a smear from the vulva urethra and vagina, expose the cervix and note the presence or absence of laceration and the character of the discharge. If the discharge is mucous entirely and a smear shows the absence of the gonococcus the case is a simple one to treat.

Leucorrhoea due to laceration in the absence of the gonococcus can be improved and even temporarily cured by local application of pure tincture of iodine and a douche, used twice daily, containing half a drachm of sulphate of zinc and one drachm of alum to the quart of hot water, but relief will never be permanent until the lacerations are repaired.

In a gonorrhoeal leucorrhoea, however, if the organism has penetrated beyond the internal os I believe that the only way to effect a cure that you can guarantee is by total extirpation of the uterus and tubes and subsequent treatment of the vagina. We cannot always do this, however. If the condition is acute it demands expectant treatment with free elimination, free drainage and applications of heat and cold. In chronic cases I have used vaccines in combination with intrauterine injections of 10 per cent iodine in oil of sesame and, in some cases, pure tincture of iodine, with moderately good results, and in one case I think I effected a cure. However, I never enter a uterus unless I am sure that the condition is chronic and that the infection has extended above the internal os and then

only after a careful toilet of the vagina and cervix and as near asepsis as one can get in the vagina with iodine.

In acute gonorrhoeal vaginitis and cervicitis I believe in daily local applications of pure tincture of iodine to the cervix up to the internal os alternating with 10 per cent silver nitrate and the applications to the vagina and urethra of iodine and albolene to the strength of 3 per cent. Absolute rest in bed at least during the menstrual period, free purgation and general dietetic measures with douches of a gallon of hot water every four hours and one consisting of silver nitrate 1-15000 once a day. Many men advise tampon treatment. I believe, however, that more damage is done by damming back the secretion than will justify the results obtained. The treatment often advised of overgrowth by yeast or lactic acid bacilli I believe impracticable.

One other thing that I endeavor to accomplish and believe to be of great service in all cases of leucorrhoea is changing the reaction of the vaginal secretion in an endeavor to check the growth of the organisms by placing them in a medium unfavorable to their best growth.

As the case improves and the purulent discharge becomes mucous, astringent douches of alum and zinc and ichthyol or boroglyceride suppositories are indicated and are of inestimable value in clearing up the condition.

Where leucorrhoea is due to misplacements, salpingitis and new growths the only relief is surgery. In the terribly offensive discharge of cancer—where the case is hopelessly inoperable—fixation with acetone and zinc chloride tampons give the best results in checking the secretions and eliminating the odor.

Summary.

1. Every case of leucorrhoea demands a careful macroscopical examination of the generative organs and a microscopical examination of the discharge.

2. Chronic gonorrhoea is too often overlooked for want of careful microscopy.

3. Changing the reaction of the discharge seems to be of some value in treatment.

4. Iodine is our best agent in treating these conditions.

5. Vaccines are of little value and cannot be depended upon.

6. Curettage is never indicated by itself as a treatment for leucorrhoea.

7. Every discharge from the vagina or cervix other than the normal menstruation, normal lochia and the mucous discharges ante-partum are abnormal and have a pathological basis. The cause is always local and usually in plain sight or at least palpably.

8. No doctor does his duty if he allows a patient complaining of leucorrhoea to leave his office without having been thoroughly examined, or if he examines such a patient without taking slides for microscopical diagnosis.

FACIAL PARALYSIS OCCURRING IN THE TREATMENT OF SYPHILIS.*

J. L. KIRBY-SMITH, M. D.,
Jacksonville, Fla.

As this contribution to the program of our annual meeting is merely a report of a certain condition met in my practice, no attempt will be made to go into the etiology or pathology of facial paralysis. No theory is advanced as to the effect of the new method used in the treatment of syphilis as causative of the condition. In other words this report is made hoping that it may interest the profession. No reference is made to the experience of other syphilographers.

During the past few years a number of writers in the current medical literature have reported complications or sequellae in the treatment of syphilis with salvarsan. Mention has been made of several condi-

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

tions said to be due to irritating properties of this drug, other than local irritation at the site of the injection. The most frequent of these has been renal irritation; the next has been the irritation of the different nerves, especially the cranial nerves.

From the beginning of the use of salvarsan, stress was laid on the importance of an examination of the eyes, ears and urine before instituting treatment. Even now it is more or less customary to carry out this procedure before administering this drug.

During the three years of general use of salvarsan or neo-salvarsan by the profession, a number of aural, eye and renal complications have been reported as following the use of the drug, but very few writers have brought before our attention the frequency of the occurrence of facial paralysis in the treatment of syphilis. For this reason the writer desires to place before the profession the following five cases of Bell palsy or facial paralysis that have occurred in the course of the treatment of one hundred and fifty syphilitics, all of whom were treated by injection of salvarsan or neo-salvarsan along with mercury. The intravenous method was used for the arenso-bezol, the mercury being given in most cases by ingestion, or intramural injections of mercury salicylate. The five cases reported all occurred within 18 months from July, 1911, to January, 1913. Two of the cases of paralysis were of short duration. In case No. 1 the paralysis cleared up in four weeks, and in case No. 2 in eight weeks. The other three cases slowly cleared up in three months, six months and eight months respectively. These five cases are not reported as being due directly to the new method of treating syphilis. In fact it cannot be stated to what direct cause the condition was due. Certainly this paralysis is seen more frequently after the use of salvarsan than after the use of the old method of treating syphilis with mercury and iodide of potash. In case No. 4 intramural injec-

tions of salicylate of mercury were given bi-weekly between the first and second injections of salvarsan. Case No. 3 was given an intravenous injection of salvarsan. Ten days later, still having symptoms of the disease, he was given another injection. This patient had not received any mercury when the paralysis was first noticed.

Case No. 1. W.G.L., office secretary, male aged 24 years, referred by Dr. C. P. Rogers, of Jacksonville.

Chancre, prepuce of the penis of six weeks duration, well developed secondaries. September 15, 1911, 10 gr. salvarsan were given intravenously, followed by reaction, chill, nausea, vomiting, and temperature 103.4 F. September 20th, all symptoms of disease disappearing; in fact, only slight induration remaining in the chancre and moderate adenopathy, patient feeling fine. On September 30th, second injection of 10 gr. salvarsan given, very slight reaction. October 10th, no clinical evidence of disease, positive Noguchi. Patient was given protoiodide of mercury, $\frac{1}{4}$ gr., t. i. d., increasing the dose to 1 gr., t. i. d. January 2, 1912, third injection of 10 gr. salvarsan followed by slight headache and chilly sensation. January 5th, patient reported with pronounced Bell palsy, left side. This developed over night. Treatment was continued. January 10th, slight improvement in the paralysis, negative Noguchi. February 1st, complete disappearance of facial paralysis. June 1st, another negative Noguchi.

Case No. 2. C. M., physician, age 48, referred by Dr. W. S. Grambling of Miami.

Chancre on index finger following an operation. Undiagnosed in early stages. First seen three months after initial lesion, patient had well developed papulo-squamous syphilides on face, body and extremities, mucous patches in mouth, marked general adenopathy.

Patient had been taking "mixed treatment." Noguchi strongly positive. On July 15, 1912, patient was given 10 gr. salvarsan intravenously, followed by chills,

nausea, temperature 103° F., digestive disturbances for several days; slight albuminuria. July 18th. developed facial paralysis, left side, was given $\frac{1}{16}$ gr. bichloride of mercury, t. i. d. August 3d, some improvement, Noguchi positive, no clinical symptoms of syphilis. August 25th, second injection of salvarsan, very slight reaction. September 1st, Noguchi positive, facial paralysis disappearing. September 20th, completely cleared up.

Case No. 3. J. R., express messenger, age 26 years, patient of Dr. W. P. Dey, chancre carona glands, three weeks duration, no secondaries, spirochetes pallida found in lesion. Noguchi negative. February 15, 1912, intravenous injection, 10 gr. salvarsan given; very slight reaction. February 25th, chancre slowly healing, protoiodide mercury given, $\frac{1}{4}$ gr., t. i. d., increasing doses. March 28th, second injection salvarsan, 10 gr., intravenously. April 15th, patient reported with marked right facial paralysis, and ocular paralysis as well, Noguchi negative. Syphilitic treatment discontinued. May 1st, slight improvement noted. Potassium iodide with increasing doses ordered. June 30th, condition about the same. August 2d, Noguchi positive, protoiodide of mercury, $\frac{1}{4}$ gr., given with increasing doses. September 15th, slight improvement. December 20th, facial paralysis completely disappeared. Ocular paralysis slight, general condition of patient fair, specific treatment continued.

Case No. 4. R. G., civil engineer, age 34 years, referred by Dr. E. N. Liell, Jacksonville. January, 1912, developed chancre on penis. First seen February 5th, macular eruption, mucous patches in mouth, beginning bi-lateral iritis, Noguchi positive. February 8th, 10 gr. salvarsan given intravenously. Slight constitutional reaction. February 14th, all symptoms controlled. Adenopathy still noticed, and slight induration remaining in the chancre. Was given intra-mural injection of mercury salicylate, 2 gr., every three days. February 26th,

second injection of salvarsan, no reaction. March 12th, Noguchi positive, mercury continued at three-day intervals. April 20th, injection of neo-salvarsan, no reaction. April 24th, patient noticed slight numbness of left side of face, Noguchi positive. April 25th, slight Bell palsy noted. April 28th, patient complains of severe pain over left eye and in left side of face. Paralysis present being more marked. April 30th, no change. May 10th, patient placed on mixed treatment. June 1st, general condition of patient good; very slight evidence of paralysis. July 1st, Noguchi negative. Paralysis completely cleared up.

Case No. 5. A. M. Martin, waiter, referred by Drs. Heggie and Hanson, Jacksonville. December 12th, patient had bi-lateral iritis, mucous patches in mouth, large ulcer in the tonsils, and papulo pustular syphilides, chancre on penis, three and a half months' duration, hard and infiltrated, had had no treatment. Patient complained of headache, bone pains, also loss of weight and appetite. December 7th, given 10 gr. neo-salvarsan intravenously. Very slight reaction. December 10th, iritis greatly improved. December 28th, patient returned, iritis not apparent, eruption disappearing, general improvement noted. December 30th, injection of salicylate of mercury, 2 gr., given intramurally every third day. January 15th, developed tonsillar ulcer, Noguchi positive, given intravenously 10 gr. neo-salvarsan. January 20th, tonsillar ulcer completely healed. Patient placed on mercury again. January 25th, right side facial and ocular paralysis developed over night, lasted three weeks, six injections of 1 gr. of salicylate of mercury given. Some improvement in paralysis. February 25th, 10 gr. salvarsan given intravenously. March 25th, positive Noguchi, facial paralysis improving but still apparent. April 5th, patient put on mixed treatment. May 1st, general condition good, paralysis not in evidence.

In a summary of these cases, I would like to call to your attention the facts, first, that all five of the paralyzes occurred in the first year of the syphilitic infection, and all responded to treatment. Second, that at the time of the occurrence of the paralysis, none of these five patients had active symptoms of the infection. Third, it is impossible to state definitely to what drug, if any, or the method of treatment this condition was due. Facial paralysis is not an uncommon occurrence in the course of syphilitic infections.

Keys reports nine cases occurring in his observation of 2,500 syphilitic patients. Certainly the five that I now report as occurring in 18 months in the treatment of 150 patients would show that the method of treatment pursued had something to do with the causation of this condition. Any irritation to the nerve, either at its origin or along its course, would produce the paralysis.

Fourth, only one case of facial paralysis has occurred in the writer's experience during the past 18 months' use of neo-salvarsan to the exclusion of salvarsan.

Fifth, another point of interest in the report of these cases is that two of them showed negative Noguchi at the time of development of the paralysis.

Sixth, three of these cases had ocular paralysis, as well as facial paralysis, showing that they were on the verge of syphilitic involvement of the central nervous system.

AN UNSUCCESSFUL ATTEMPT TO PROVOKE VOMITING. REPORT OF A CASE.

FREDERICK J. WALTER, M. D.,
Daytona, Fla.

Mr. B., white, aged 70, of about 200 pounds weight, was referred to me by Dr. C. C. Bohannon after an attempt to remove from the throat a supposed piece of bone. The patient had suddenly choked while eating meat. He had poor teeth and his food could not be well masticated. Having

a very short neck and a small mouth the examination was not satisfactory and nothing could be seen with the laryngoscope and good electric illumination, assisted by a topical application of a 5 per cent solution of cocaine. The man's breathing was good, though he was much distressed mentally. He insisted that he was in great distress by something being "lodged here" (pointing to the suprasternal notch). After using an esophageal expanding hair probang unsuccessfully four times I reluctantly decided to try emesis, hoping to dislodge the substance in this way. Titillation of the throat and epiglottis was tried several times without result. He was given an emetic dose (4 to 6 drachms) of syrup of ipecac. In thirty minutes he was given 20 grains of zinc sulphate, followed in fifteen minutes by a large tablespoonful of pulverized mustard in an equal quantity of lukewarm water. In ten minutes 20 grains of zinc sulphate was repeated and in five minutes more mustard (amount not certain). At this time two pints of lukewarm water were given, all of which produced no emesis. In ten minutes one-tenth grain of apomorphin hydrochlorate was subcutaneously injected with no result, except in fifteen minutes a tendency to be a bit stupid. It seemed wise to try another make of the apomorphin; this was done and the second dose of one-tenth grain being given without the slightest nausea. It did not seem safe to leave these drugs taken by mouth in the stomach so I washed the stomach out with two quarts of warm water, hoping at the time for some reaction by means of the tube. The man became weak, relaxed and was perspiring from the apomorphin and the ordeal. He was put to bed and allowed to sleep. In one hour and thirty minutes he awakened gulping (not vomiting) up a piece of tough, irregular roughened cartilage the size of an egg with entire relief.

This case the writer thought would be of general interest for the following reasons:

(a) Because so large a mass could exist

and not be disturbed by probang or stomach tube unless a diverticulum were present (symptoms of which there were none other than the above).

(b) Because of the quantity and the variety of emetics given without the slightest result.

(c) Because of the manner in which the cartilage was finally ejected.

SHOULD THE PHYSICIAN DISPENSE HIS OWN REMEDIES?*

A. H. FREEMAN, M. D.,
Starke, Fla.

This question has been much debated in medical and pharmaceutical publications for several years, some physicians contending that they should dispense while the retail drug man vehemently says they should not be allowed to do so. Druggists, well organized and with effective lobbying, have invaded our legislatures and secured various restrictions in some states which limit our men in issuing drugs to sick people.

Maine physicians are compelled to keep a record of all narcotics dispensed and are limited to four grains of any narcotic. In Ohio and Kansas State Pharmacy Boards may inspect the stocks of medicine of the dispensing physicians and fine him if anything is not satisfactory to them. In Nevada one must first get a pharmacist's license to be able to dispense remedies to patients. One cannot give a hypodermic of morphine without a pharmacist's license. In some of the proposed laws a physician can not give a hypodermic or a dose of morphine to a habitue, without filing a copy of the prescription with the Board of Pharmacists.

The N. A. R. D., in convention at Cincinnati, in 1913, passed the following resolution: "Resolved, That physicians who choose to be their own pharmacists shall

furnish their patients with prescriptions for all remedies supplied, and that in case of fatal termination where physicians have dispensed their own medicines, the local health authorities shall certify the cause of death."

These are just a few samples of the activities of organized druggists in their effective efforts to retain the control of the sale of remedies for diseased conditions. That they propose to make it impossible in every state for any but licensed pharmacists to dispense any and all drugs cannot be doubted for a moment.

The physician must dispense in all emergencies. He cannot send one, ten or twenty miles for some needed remedy; he must have it with him and administer it or be of little service to the patient. Most calls are really emergencies.

We should dispense all anodynes, narcotics, hypnotics and nervines to prevent prescription being refilled and thereby contributing to the formation of drug habits. We must dispense hypodermic remedies as well as intravenous and intramuscular ones.

Fifty per cent of the physicians in the United States are not near enough to a drug store to write prescriptions, and of necessity must dispense. Small towns cannot afford to pay two men to handle their drugs. They may *want* the druggist but they *need* the doctor; better that one man should do the work well than that two men should do it poorly.

The public generally has a few emergency remedies, and the physician who goes unprepared to meet urgent conditions is not wanted. He must supply treatment needed, at least temporarily.

We should dispense in all acute illnesses and watch the effect of the first dose; the result will be a greater percentage of cures.

We should dispense because it is a part of our work to see that the patient is cured of his malady, and if drugs be necessary to the cure we should satisfy ourselves beyond the peradventure of a doubt that he gets

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

what we want him to have. There can be no surer way to do this than to dispense the remedy ourselves.

Our knowledge of drugs will be increased by handling them. Color, taste, physical characteristics, solubility, compatibility, are more familiar to us if we dispense. As our knowledge of drugs and drug action increases, an increased faith in drugs will come. We will notice a tendency to use fewer drugs in a combination, and often to the use of single drugs to do our work. This leads to precision in drug use, the giving of a definite remedy to secure certain definite results.

If we administer the needed remedy without waiting for minutes or hours for the drug man to send it, we will often see the effects of our first dose, and we will know more of drug action than if we used the other plan. This is case study and leads to precision in giving medicine.

In dispensing you need give only enough medicine to last until the next visit, then no costly drug is wasted, no part of an unused prescription need be dumped into the garbage can, no big drug bill is piled up; and, if the condition of the patient requires a change in the medicine, it can be done with less criticism than in prescribing. Dispensing keeps the physician in closer touch with the patient because one intermediary is removed; one less chance for mistakes to be made is cancelled. You will more quickly discover weak and inert drugs, thus securing greater uniformity in results.

Out of 9,000 samples of six pharmaceutical products which the U. S. Hygienic Laboratory examined in the years 1907 to 1911, inclusive, 4,000 failed to come up to the requirements. Examinations made in Indiana showed 42.7 per cent illegal. In South Dakota, 36.3 per cent failed to pass, and in New Hampshire 42.8 per cent failed to conform. What do you suppose becomes of these and other inert drugs on the shelves of drug stores over this country? May this condition not explain the wave of drug ni-

hilism that swept over us a few years ago?

Quoting from an article written by Martin I. Wilbert, assistant in Pharmacology of the U. S. P. H. S., published in Public Health Reports of May 8, 1914, we read as follows: "How little actual reliance can be put in the average drug preparation at the present time will be appreciated when we learn that fully 50 per cent of such widely used articles as aromatic spirits of ammonia, spirits of camphor, tincture of iodine, tincture of opium, spirits of peppermint and spirits of nitrous ether have been found to be adulterated or below standard." It looks as if somebody should sweep under his own doorsteps.

Drugs deteriorate from many causes, some of which are not under our control. This fact would argue for careful selection of our medicaments as to quality, freshness, standardization, etc.; when we can get them, the use of remedies that are stable.

We should dispense because we are more competent to do it than the average drug clerk. If we are competent to diagnose the case and write instructions about the preparation and giving of the medicines, we ought to be competent to dispense them.

Dispensing is not the problem it once was. Making pills, powders, boluses and suppositories once took much time, and the doctor had to have a helper. This helper grew into the apothecary. Some thrifty men began making pharmaceuticals on a larger scale and selling to retail men. Thus the manufacturing pharmacist had his beginning, and later took over the big end of the business because he could make them more elegantly and cheaply than others not having his facilities. The big man got the small man's job and the latter had to turn to soda-water, sundries, patents, Vexall remedies and counter prescribing to make ends meet. The physician is now waking up to the fact that his one-time coworker and helper has become his competitor, without the training of the medical man or knowledge of diseased conditions; for without license or law

the pharmacist treats many minor ailments and some that are major, with one hand, and with the other solicits the prescriptions of the physician.

Our prescriptions, representing oftentimes the study and observation of years are a part of our active capital. To give these away is to rob ourselves and enrich some drug man who had no part or parcel in the creation of this capital. Thousands of prescriptions are refilled for the patient long after the need is past; refilled for his family and the neighbors and friends and sold to anyone who will buy, oftentimes long years after the physician is dead.

Keep your assets by dispensing. If refills are needed you, if anyone, are entitled to make them. To prescribe advertises the remedy used to the patient and his friends. This often leads to self-prescribing, a pernicious and harmful habit. If a patient needs medicine at all, he should have it from someone who knows why he needs it and what he needs. By advertising remedies to patients through prescription writing, most drug habits have been made. Keep your capital intact by dispensing.

Prescribing gives an opportunity for derogatory remarks of the druggist or clerk and to the loafing doctor if either be unfriendly.

We should dispense in order to retain our influence over our patient and to avoid publishing his ailment to the world, and to know what he is getting.

Dr. Oscar Dowling, president of the Louisiana State Board of Health, reports a test recently made in New Orleans to find out to what extent substitution was practiced in prescription filling. 68 druggists filled a prescription calling for 2 grs. of boric acid in 2 ounces of distilled water. 20 were filled correctly. 16 used 2 grs. of the drug but not the distilled water. 7 used distilled water but incorrect weight. 25 used the wrong amount of drug and no distilled water. One druggist used as little as $\frac{3}{4}$ of a grain, and one 29, another 33 grs. to the two ounces.

The chance to get a prescription correctly filled in New Orleans is therefore as 1:3. We might do better in Chicago. Tests made there show that 108 druggists used worthless substitutes for a well known drug and that only 31 filled it correctly. Let's try New York. 300 prescriptions were filled there and 50 per cent found to be harmful or worthless. The testimony revealed frauds of all kinds in putting up these prescriptions.

Consequently in order to know what your patient is getting, it is safer to dispense. If any substitution must be done, the physician should do it.

The accuracy and sensitiveness of scales, weights and measures are important items. The Hygienic Laboratory found that not one of 36 graduates examined was correct. In Kansas the Inspector was forced to condemn nearly one-half of the weights examined, and found that 195 out of 718 prescription scales were unfit for use.

Moreover the average modern druggist has no time to practice pharmacy; he is too busy pushing the propaganda of N. A. R. D., selling soda water, candy and patent medicines. The Vexall Remedies fit every ailment and occupy the center of his stage.

The average druggist has done what he could, inadvertently of course, to drive the doctor away from him—now he howls because he is going.

Most patients prefer the doctor to dispense, because the remedies are at hand and medication can begin at once, the physician watching the effect of his first dose if need be.

Because it protects the patient from having his ailment advertised or discussed by clerks.

Because the patient feels more security in having the doctor dispense his medicines (remedies): they rightfully believe the physician has a more vital interest in seeing that they get well than the druggist has.

Because they believe there will be fewer errors occur, less substitution, better drugs

used, and more accurate directions given. They believe we cure them more quickly, use less drugs and save them money. It is an everyday occurrence to have patients ask us to put up the remedy ourselves and *rare* to have them ask for a prescription.

A certain number of patients fail to see any value in the piece of paper (the prescription) you give them. They think they are getting more for their money if handed the remedy needed.

If given a prescription many patients will report to the druggist instead of to you, and the case passes out of your hands. I know one druggist who makes a business of telling patients to come to him for refills to save the doctor's fee.

If the druggist is practicing medicine, and I know of very few who do not, then we must, in self-defense, dispense our remedies and take care of what is rightly our own. To offset patent medicine pushing, Vexall and Senslar remedies and counter prescribing, we are forced to dispense.

The welfare of our patient is our first consideration. To cure his complaint and restore him to health, teach him how to get well, stay well and live a long, happy and useful life is our duty. Whatever is required to attain these ends should and must be under our control or we shall fall far short of our aim. Our only excuse for writing a prescription should be when we have not the remedy our patient needs. This course is best for you, protects your assets, makes you more money, protects the patient, avoids substitution, short weights and inert drugs, reduces errors and cures the patient more quickly and with less cost. It will lessen the formation of drug habits, and the pernicious, dangerous and costly practice of self-dosing. It will retain in your possession the knowledge of a lifetime of study and observation, a knowledge which if used unwisely is capable of great harm. This policy will increase our incomes, make us closer students of medicine, better physicians and hasten the day when

those who need medicine will neither treat themselves nor consult some other person who is wholly ignorant of the pathologic condition present and the proper means to remedy it.

PROPAGANDA FOR REFORM.

GLYCOTHYMOLINE NOT HARMLESS.—GlycOTHymoline is a mild antiseptic practically devoid of germicidal power and when used as a simple mouth wash is practically harmless. However, the recommendations to the public for its use in serious diseases make it a menace to the public health—and physicians are responsible for its widespread use. (*Jour. A. M. A.*, Oct. 10, 1914, p. 1304.)

LACTIC ACID FERMENTS.—There is a large amount of literature to the effect that the *Bacillus bulgarius* hinders putrefaction in the intestinal canal. While there may be some question as to a greater success in securing the implantation of this bacillus by administering it in "liquid cultures" the report of the Council on Pharmacy and Chemistry shows that such a culture is likely to reach the consumer in a more active state than one in the form of tablets. (*Jour. A. M. A.*, Oct. 3, 1914, p. 1223.)

SEROBACTERINS.—While objection may be made to the sensitized living bacteria used by Besredka because there is always an uncertainty as to the action of living bacteria in the animal body, such danger can not be attributed to the "serobacterins" because they contain dead bacteria, and so far as known, can do no more harm than other dead bacteria—in fact it is claimed that they are preferable to other vaccine because the toxic products of the bacteria, other than the immunizing properties, have been largely removed. It must be said, however, that these preparations are still in the experimental stage. In great part, careful clinical observations will decide that the serobacterins are really superior to ordinary vaccines. (*Jour. A. M. A.*, Oct. 3, 1914, p. 1223.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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DO "PATENT MEDICINE" INTERESTS CONTROL THE PRESS?

In its issue for December 5, *The Journal of the American Medical Association* comments on a piece of correspondence from Mr. Samuel Hopkins Adams, who says in part:

"To the Editor:—Any suggestion that the daily press is subservient to dishonest advertising interests is received with instant and fervid indignation by 95 per cent. of the newspapers. Just about this percentage takes money for obviously crooked advertising, in the form of quack medical 'copy.' As the subject of much of this virtuous journalistic wrath on account of my recent novel 'The Clarion,' I wish to point out an instance in the career of the book itself which curiously supports my contention.

"Birmingham, N. Y., is the home of Swamp Root, a conspicuous 'booze-medicine' which I exposed a few years ago in *Collier's Weekly*. It is a prosperous and thriving city of almost 55,000 inhabitants, served by two local newspapers, the *Press* and the *Republican-Herald*. Just before the appearance of 'The Clarion,' the publishers sent to the *Press* an advertisement of the book specially designed to arouse the local interest of a city largely devoted to the patent medicine industry. The copy was returned. * * *

"As the *Press* had formerly been owned by the Kilmers, proprietors of Swamp Root, its indisposition to advertise a work dealing with the proprietary medicine evil might be attributed to a legacy of loyalty to old standards. No such inhibition would apply to the *Republican-Herald*. The first, or local advertisement was sent to that office, bringing with it tribulation of spirit to the business staff. They did not like to reject the advertising. All newspapers particularly appreciate publishers' business, as a mark of 'class.' But they felt, evidently, that the proffered 'copy' was too near home, and they wrote asking if it could not be modified somewhat. Thereupon the regular stock

advertisement of the book was forwarded. What occurred in the office in the meantime is a matter of conjecture only. But the outcome is sufficiently significant. 'Owing to a peculiar agreement existing between the Binghamton newspapers' (I quote from the letter of the advertising agency acting for the publishers) the *Republican-Herald* felt compelled to decline all advertising of this particular book!

"Meantime the local book-stores refused to order it, although it was having one of the largest advance sales of the year in other parts of the country. One store made no secret of the fact that fear of the Swamp Root interests kept the novel off their shelves. It was not even obtainable at the local public library. Since this letter was written, however, I understand that the library has put it in, and the book department of a general merchandise store which at first rejected it, is now carrying the book.

"All of which would seem to indicate that my fictional city of 'Worthington' with its press under the domination of 'our leading citizen,' Dr. Surtaine of 'Certina' fame, is not perhaps so wholly absurd and foundationless as the *New York Times*, the *San Francisco Chronicle* and others of the noble band of newspaper defenders would have their public believe.

"SAMUEL HOPKINS ADAMS,
"Auburn, N. Y."

The Journal says: "Most of our readers are familiar with the 'Great American Fraud' articles by Samuel Hopkins Adams that appeared in *Collier's* a few years ago. In preparing the matter for the 'Great American Fraud,' Mr. Adams visited 'patent medicine' factories, got in touch with nostrum promoters—and their dupes—and in various ways investigated the subject with the utmost thoroughness. In connection with that series there were one or two articles showing the sinister control that the 'patent medicine' interests exercised over the press of the country. The notorious 'red clause' in advertising contracts, by which

the 'patent medicine' makers hoped to enlist the aid of the newspapers as unpaid lobbyists against any proposed health legislation that might interfere with the sale of nostrums—this is history. That the 'patent medicine' interests still exercise a baneful control over the press is evident from the facts brought out in a letter from Mr. Adams published in this issue. In his latest novel, 'The Clarion,' Mr. Adams has put in vivid and gripping form the information he has gained as a newspaper man, and his wide and yet detailed knowledge of quackery and the 'patent medicine' business. It is not necessary here to give a synopsis of 'The Clarion'; this was done when the book was reviewed recently. It is sufficient to remind our readers that the novel deals with the problems that beset a newspaper that tries to be honest with its patrons. The chief character in 'The Clarion' is a 'patent medicine' manufacturer, one 'Dr. Surtaine,' whose nostrum 'Certina' brought him wealth and power. Readers familiar with the history of contemporary quackery will recognize in Surtaine a composite picture of several individuals who have amassed wealth through the sale of worthless, fraudulent or dangerous nostrums. If one wished to clothe the intangible, to particularize the general, to materialize the immaterial, he could, as fancy led him, recognize in Mr. Adams' hypothetical nostrum 'Certina,' such products as 'Swamp Root,' 'Peruna,' or a score of others. It is evident from Mr. Adams' letter that the newspapers and bookstore proprietors of Binghamton, N. Y., have materialized 'Dr. Surtaine's' preparation in the notorious fraud, 'Swamp Root.' Such might have been expected. But it is a little disheartening to those who were hoping against hope that the newspapers were throwing off the yoke of the 'patent medicine' makers, to find that there are still newspapers so truant to their public trust as to refuse to advertise a novel because it may throw an unpleasant light into the dark places of a local industry."

CROTALIN IN EPILEPSY.

The claims made by those advocating the use of crotalin in the treatment of epilepsy have been based upon the assumption that the coagulability of the blood is increased in this disease and that crotalin decreases it. An active advertising campaign has been carried on in the commercial interests of this cure for epilepsy and extravagant claims have been made by those advocating this line of treatment. *THE JOURNAL* wishes therefore to call attention to a recent report published in the *Journal of the A. M. A.*, by Jenkins and Pendleton.*

In this article the authors report their observations on the effect of the treatment in a large number of patients under their care at the Epileptic Colony at the Hospital of North Carolina. They entirely refute the claims of those who have advocated the rationale of the treatment demonstrating that the coagulability of the blood is not necessarily increased in epilepsy and further that crotalin not only fails to decrease, but instead produces a transient increase in the coagulability.

They conclude their article by stating that "The blood of epileptics is less coagulable than that of normal persons, and the coagulability is transiently increased by the use of crotalin. The number of convulsions is increased by its use and in direct proportion to the amount used. Its uses seem to have no effect upon the mental condition of the patient, all of which is absolutely contrary to the claims of the advocates of the treatment. Its use does, however, to a certain extent, satisfy the abnormal craving for medicine which all epileptics have."

MEDICAL LEGISLATION.

There appears in another column of *THE JOURNAL* a communication from the Secretary of the Dade County Medical Society

that raises a question which should be given careful consideration by the members of the profession throughout the state. The various members that constitute the upper and lower houses of our legislature will consider more carefully matters pertaining to medical legislation if they are presented with the facts by the members of the profession whom they know personally. In this manner the individual member can be reached—a few words from his family physician will have more weight than volumes of petitions signed by the profession at large and presented at committee hearings. Our Committee on Legislation and Public Policy intend to present at the coming meeting of the Legislature a bill regulating the practice of medicine in this state. It is high time we had on our statutes a bill in conformity with the general progress that is being made in medical legislation throughout the country. We therefore urge all readers of *THE JOURNAL* to make it a point to personally see their representative and discuss with them the various matters pertaining to medical legislation that will be brought to their attention at the coming session of our state governing body. For the ready reference of our readers we publish elsewhere in this issue the complete personnel of the Senate and House.

NEW MEMBERS.

Since the last annual meeting of the Association, held in Orlando, we have added to our membership roll seventy new members, making our total present membership 550. With the advent of a new year let each member make an effort to further increase the number. Every added member to the State Association is far reaching in its effects. Apart from the benefit that will accrue to the new member, organized medicine throughout the state is benefited. The larger the circulation of *THE JOURNAL*, the greater revenue from its advertising pages, the greater the revenue the better a journal

*Jenkins, C. L., Pendleton, A. S.: Crotalin in Epilepsy, *Journal A. M. A.*, Vol. LXIII, No. 20, 1914, p. 1749.

we can publish. It is then easily seen that every member should be interested in securing additional members. Let every county society unit and the individual members of these units work with a will. We have over twelve hundred physicians in the State. Our organization in the near future should include at least a thousand of this number.

COUNTY SOCIETY NEWS.

BAY COUNTY.

At a meeting of the Bay County Medical Society held on December 5th, the following officers were elected for the ensuing year:

J. M. Nixon, Millville, President.

W. H. Mitchell, St. Andrews, Vice President.

Wm. Davis Cawthon, Panama City, Secretary.

Allan H. Miller, Millville, Treasurer.

W. G. Lowe, Lynnhaven, Member Board of Censors.

DADE COUNTY.

To the Florida County Medical Societies:

At the last regular meeting of the Dade County Medical Society, the Secretary was requested to solicit the earnest and hearty co-operation of all the medical societies of the state, and take up the matter of physicians' license fees for county and state and use their influence through the proper channels to have the law compelling physicians to pay state and county license fees repealed.

We think this law unjust when we consider the large amount of charity practice done by the profession who also give their hearty support in all ways and means to the prevention of disease.

There is an element of altruism which we venerate—that the practice of medicine is not a business in a commercial sense, and having it brought to that basis by having to pay a tax for the privilege of practicing our noble profession would be like levying a tax

on the minister of the gospel for the privilege of preaching.

Gentlemen, will you not take this matter up and have some action taken by the next legislature?

Very truly yours,

HOWARD SWITZER,

Secretary-Treasurer.

Miami, Fla.

DUVAL COUNTY.

At the December meeting of the Duval County Medical Society the following officers were elected for the ensuing year:

C. M. Sandusky, President.

J. K. Simpson, Vice President.

W. W. McDonell, Secretary-Treasurer.

C. L. Jennings, Member Board of Censors (one year).

W. P. Dey, Member Board of Censors (3 years).

Delegates to the State Association Meeting: R. H. McGinnis, J. D. Love, W. E. Ross, J. H. Pittman, F. J. Waas.

OSCEOLA COUNTY.

At a meeting called in the town hall, Kissimmee, Fla., a reorganization of the Osceola County Medical Society was effected and the following officers were elected:

M. J. Hicks, President.

T. M. Rivers, Vice-President.

H. S. Geiger, Secretary and Treasurer.

C. L. Hyatt, Chairman Programme Committee.

The fact that so many of the county societies are in a quiescent state, not having held meetings for years, can but deplete the vitality of the state organization and it seems to me that you should have a column devoted to news from the councillor districts. So far I have gotten Volusia, Brevard and Osceola to work and am planning to move on St. Lucie. The Orange County Society is a splendid organization and needs no prodding. Seminole County meets with Orange County.

Fraternally,

DAVIS FORSTER,

Councillor Seventh District.

[NOTE.—The suggestion contained in the foregoing communication is a most excellent one and we would appreciate its adoption by the various Councillors throughout the state.—Ed.]

PASCO COUNTY.

At a very enthusiastic meeting of the Pasco County Medical Society, held in Dade City on the evening of the 9th inst., the following officers were elected for the ensuing year:

H. O. Byrd, Trilby, President.

R. D. Sistrunk, Dade City, Vice President.

H. W. Wade, Dade City, Secretary-Treasurer.

ASSOCIATION NEWS.

A meeting of the Committee on Arrangements for the next meeting of the Florida Medical Association was held at the office of the Chairman of the Committee, Doctor John McDiarmid, in DeLand, on Tuesday, December 1st, at 5 o'clock p. m.

This committee appointed by the Volusia County Medical Society is constituted as follows:

Drs. MacDiarmid and Stephens of DeLand, Bohannon and Rawlins of Daytona, and Bouchelle and Forster of Daytona.

AMERICAN PUBLIC HEALTH ASSOCIATION.

The Forty-second Annual Meeting of the American Public Health Association, held in Jacksonville November 30th to December 5th, was conceded to be one of the most successful meetings the organization has ever held. The attendance was the second largest in the history of the Association, numbering nearly 300 delegates and over 60 guests. The program of scientific papers appeared in the last issue of this JOURNAL.

The address of the President, Dr. Wm. C. Woodward, while touching upon many

aspects of public health activities, dealt especially with the non-economic expenditures of funds and energy occasioned by the existence of so many organizations interested in one aspect or another of health conservation work, and expressed the hope that the future would bring about an amalgamation or at least a closer co-operation of these many organizations, in this way making for greater efficiency.

Of all the discussions indulged in at the general sessions it is probable that the one relating to the spread, in this country, of the habit-forming drug evil is pregnant with the greatest promise of results. The group of papers presented covered well-nigh every side of this national problem and definite action was taken by the Association through the adoption of a resolution creating a standing committee on habit-forming drugs whose duties it should be to make an exhaustive study of the etiologic factors entering into the rapid spread of drug addictions, the present status of legislation in this country, the attitude of the press and public and to make recommendations which might seem advisable. That modern health conservation deals not only with the spread of contagion but occupies itself with many conditions making for improved citizenship is significant from this action of the American Public Health Association.

Of especial interest to the sanitarians of the South were the symposia on the Negro Health Problem and Rural Sanitation. These subjects were handled by the most part by southern men and one and all voiced the sentiment of all southern health officials in that no problems presented greater difficulties for solution or promised more brilliant results if accorded the research and application they deserved.

Typhoid, diphtheria and other disease carriers received considerable attention in the various section meetings as bearing closely on the prevention of the diseases concerned. New laboratory technique relating to their detection was reported and

the discussions evoked indicated plainly the importance of the carrier in disease prevention.

Altogether it was the unanimous opinion of those in attendance at the meeting that no better scientific program has ever been presented and it is felt that the Association, dealing with the health problems of this continent, has reason to congratulate itself upon both the activities of its members and the public recognition it has received.

Rochester, New York, has been chosen for the next meeting place. The exact date will be determined later.

The holding of this convention is of immense benefit to the community involved and it is felt that not only in Florida but throughout the South has sanitary achievement received a distinct impulse.

ARMY MEDICAL CORPS EXAMINATIONS.

The Surgeon-General of the Army announces that preliminary examinations for appointments of First Lieutenants in the Army Medical Corps will be held on January 11, 1915, at points to be hereafter designated.

Full information concerning these examinations can be procured upon application to the "Surgeon-General, U. S. Army, Washington, D. C." The essential requirements to secure an invitation are that the applicant shall be a citizen of the United States, shall be between 22 and 30 years of age, a graduate of a medical school legally authorized to confer the degree of Doctor of Medicine, shall be of good moral character and habits and shall have had at least one year's hospital training as an interne after graduation. The examinations will be held simultaneously throughout the country at points where boards can be convened. Due consideration will be given to localities from which applications are received, in order to lessen the traveling expenses of applicants as much as possible.

In order to perfect all necessary arrangements for the examinations applications must be completed and in possession of the Adjutant-General at least three weeks before the date of examinations. Early attention is therefore enjoined upon all intending applicants. There are at present twenty vacancies in the Medical Corps of the Army.

THE SOUTHERN MEDICAL ASSOCIATION.

The eighth annual meeting of the Southern Medical Association was held under the presidency of Dr. Stuart McGuire at Richmond, Va., November 9-12. The meeting, as anticipated, was the most successful of the many splendid meetings this organization has enjoyed. 962 out of a total membership of 3,900 registered during the session. A public session was held in the auditorium of the Jefferson Hotel the evening of November 9th, addresses being given by Ex-Governor R. M. Cunningham of Alabama and Dr. Harvey W. Wiley of Pure Food fame. Following adjournment the members of the Association and their guests were entertained at a smoker given by the Richmond Academy of Medicine and Surgery. The Association was called to order Tuesday morning by Dr. McGuire Newton, Chairman of the local Committee of Arrangements. Addresses of welcome were delivered by Hon. J. Taylor Ellyson, Lieutenant-Governor of Virginia; Hon. George Ainslee, Mayor of Richmond, and Dr. Joseph A. White. Dr. Frank A. Jones, a former president of the organization, replied in behalf of the Association. Dr. Stuart McGuire then delivered his Presidential address entitled, "The Profit and Loss Account of Modern Medicine." He was followed by Dr. W. S. Thayer who delivered the Oration on Medicine, his theme being, "The Importance of Simpler Methods of Physical Examination in Medicine." The subject of the Oration on Surgery delivered by Dr. John A. Wyeth; of

New York, was "Surgical Comments—Chiefly Personal."

The reports of the Councillors and the Secretary-Treasurer concluded the session. At a public session held Tuesday evening addresses were delivered by Dr. Cary T. Grayson, Surgeon U. S. Navy, and Dr. Howard A. Kelly of Baltimore. A reception and dance concluded the day.

Work in the various Sections held the members' attention throughout Wednesday, the visiting ladies being entertained at luncheon at the beautiful home of the Country Club of Virginia. At the public session Wednesday night the program included addresses by Surgeon-General Blue of the U. S. Public Health Service; Dr. George H. Simmons, Editor of the Journal of the American Medical Association, and Dr. W.

L. Rodman, of Philadelphia, President-elect of the American Medical Association. At the close of the session a reception was tendered the members and their guests by Dr. Stuart McGuire at the Commonwealth Club.

At the concluding general session Thursday morning, upon the recommendation of the Councillors, the following officers were elected for the ensuing year:

Oscar Dowling, of Shreveport, La., President.

R. C. Dorr, of Batesville, Arkansas, and McGuire Newton, of Richmond, Virginia, Vice Presidents.

Seale Harris, of Mobile, Alabama, Secretary and Treasurer.

Dallas, Texas, was chosen as the place of meeting in 1915.

Reviews from Current Literature

CANCER VACCINE AND ANTI-CANCER GLOBULINS.

Vaughn, J. Walter: Cancer Vaccine and Anti-cancer Globulins as an Aid in the Surgical Treatment of Malignancy. Journal American Medical Association; 1914, Vol. LXIII, p. 1258.

Vaughn reports results obtained in one hundred cases of cancer treated by the so-called specific methods after observation of from one to six years.

Vaughn has discontinued the use of prepared sheep and rabbit serum as the ferment vehicle because of serious serum complications, notably serum sensitization of the recipient and acute nephritis, and is working toward the perfection of a ferment derived from sensitized large mononuclear leucocytes which shall be free of undesirable serum proteins. The new product has been termed "anticancer globulin."

Of the one hundred cases reported, fifty were inoperable or exhibited so extensive a recurrence that secondary operation was impossible. Of these, two are apparently cured and four markedly improved.

Of fourteen cases of definite recurrence after operation, six are apparently well and three are improved.

Of thirty-one advanced cases in which radical operation was performed in conjunction with specific treatment, twenty-three are apparently well.

Vaughn states that the best results are obtained in "cases in which the amount of cancer tissue is small and in which the differential leucocyte count of the patient shows a decided reaction following the demonstration of the cancer protein," and in cases which show immediately a marked increase in the percentage of the large mononuclear leucocytes.

Apparently intraperitoneal injections are most effective because of the protein coming in contact with a great number of body cells.

Vaughn advocates a preliminary intraperitoneal injection of cancer residue twenty-four hours before operation, and unless the percentage of large mononuclear leucocytes immediately increases from fifteen to

twenty-five per cent an injection of globulin is given following the operation.

Vaughn in his closing discussion calls attention to the numerous, marked and rapid recurrences following operation on small cancers, and the frequent late or non-recurrence after operation on large cancer masses. He states that this is due to the fact that the blood of the patient with a large cancer has produced and contains a specific anti-cancer ferment, and argues from this that if this specific ferment is artificially produced before operation recurrences will be fewer.

R. C. T.

BRACHIAL NEURITIS.

Hamilton, A. S.: *Cervical Ribs as a Cause of Brachial Neuritis*; *Lancet*, 1914, Vol. XXXIV, No. 32, abs. by Surg. Gyne. and Obst., Nov., 1914.

Cervical ribs are abnormalities arising from the anterior surfaces of the transverse vertebral processes. They usually develop from the seventh cervical vertebra, but one rib is most often larger than the other. They vary in size from a simple increase in the normal nodule to those which extend to the first true rib, its cartilage, or to the sternum.

When well developed a cervical rib may displace the subclavian artery and the brachial plexus upward and thus produce circulatory or neural symptoms.

Sensory symptoms are usually those of pain extending from the shoulder to the hand, most severe in the area supplied by the eighth cervical and first thoracic nerves. The pain is increased on exercising.

Motor symptoms are frequent and muscular atrophy has been observed.

The etiology of all cases of neuritis of the upper extremity should always receive most careful consideration; too often such cases are treated symptomatically without benefit. Syphilis, alcoholism, deficient blood supply and unsuspected cervical rib are all causes, and must be carefully differentiated. Every persistent case of brachial neuritis should have an X-ray examination.

R. C. T.

RELIEF OF GAS PAINS.

Kenefick, T. A.: *The Relief of Gas Pains After Appendectomy*. *N. Y. Med. Journal*, 1914, Vol. C, No. 19, p. 921.

The writer recommends the administration of acetyl-salicylic acid ester, grains twenty, with calomel grain one, and sodium bicarbonate, grains five, in four ounces of water the afternoon before operation as a preventive of the distressing gas pains that so commonly follow even a simple, clean appendectomy. An enema is given the morning of operation.

Kenefick has tried the method in fifteen successive cases with satisfactory results.

R. C. T.

TRIFACIAL FORAMINA.

Kanavel, Allen B.: *Osteoplastic Closure of the Trifacial Foramina*. *Journal American Medical Association*, 1914, Vol. LXIII, p. 1245.

As a result of experimental work Kanavel suggests the avulsion of affected peripheral nerves and the plugging of their canals with fresh bone transplants in selected cases of trifacial neuralgia. Careful avulsion of the nerve trunk, curettage of the canal and complete closure with the fresh bone plug apparently prevents the escape of the nerve with its subsequent recurring pain after regeneration. Naturally this procedure does not prevent return of pain backward along the nerve which has been arrested at its foramin of exit. Eliminating the use of foreign bodies as plugs is a distinct technical advance. The work is done under local anesthesia.

Kanavel states that the method is not designed to replace intracranial resection of the Gasserian ganglion or injection of alcohol into the roots of peripheral nerves, where such procedure are indicated, but that its field of usefulness is limited to patients who are not good surgical risks, who refuse radical measures, or who derive no benefit from injections of alcohol.

R. C. T.

STREPTOCOCCIC ARTHRITIS

O'Connor, J.: The Surgical Treatment of Streptococcic Arthritis. London Lancet, 1914, Vol. CLXXXVII. No. 224, abs. by Surg. Gynec. and Obst., Nov., 1914.

The results in O'Connor's work offer another authoritative proof that so called "acute rheumatism" is always a septic arthritis, due to a pathogenic organism, usually streptococcus, which is conveyed to the joint from a diseased tonsil, decayed tooth, infected sinus, septic gall bladder or some lesion of the intestinal mucus membrane, through the blood stream.

All cases of so called "acute rheumatism," "acute rheumatic arthritis," etc., which do not respond promptly to medical treatment should be operated. The affected joints should be opened, the turbid lymph evacuated and the joint cavity irrigated. Drainage should be instituted by tubes; areas of peri-articular cellulitis should have multiple incisions and hot applications should be applied. The joints should be put up in splints for about ten days, after which passive and active movements are instituted. The joints should be massaged as soon as the wounds are healed.

O'Connor has operated on 214 cases of sub-acute arthritis during the past ten years with no mortality. In no case was there septic infection, nor did a valvular lesion develop in a single instance. The results were invariably satisfactory.

The author suggests that the term "streptococcic arthritis" be definitely adopted for these cases.

R. C. T.

SCARLET FEVER.

Glaser, F.: Salvarsan in Scarlet Fever. D. M. W., 1914, No. 38.

The author treated 42 cases, of which 3 were hopeless, and 15 of doubtful prognosis. In about one-half of the cases the injection was followed by a decided drop in the temperature. The severe local throat conditions began to improve early. The severely toxic cases showed no improvement. In

more than one-half of the cases the injection was temporarily followed by chills, vomiting and diarrhea. No influence was manifested in the exanthem. The complications of the disease were not prevented.

T. T.

TETANUS.

Kreuter, Prof., Erlangen: Practical and Important Viewpoints on Tetanus. M. M. W., Oct. 6, 1914.

Tetanus is undoubtedly the most feared wound infection. Martial wounds are especially liable to harbor it. Nothing about the appearance of the wound offers an indication of its presence. Experience has taught that lacerated wounds and compound comminuted fracture wounds, also wounds that have ground rubbed or pressed into them, are especially liable to harbor the tetanus bacillus. Wounds in which saprophytes unfold their activities are often fateful. Since the tetanus bacillus is not a pus organism, it causes no interference with the healing of wounds.

The prophylactic use of anti-tetanic serum is an established procedure, and all suspicious wounds should demand prophylactic serum injections. A large quantity should be injected under the skin before the appearance of symptoms. We are unable to estimate how much good results from these prophylactic injections because of factors which we can not ascertain, *e. g.*, the presence of the tetanus bacillus, its numbers, its virulency, the patient's resistance, etc. Mild infections can certainly be prevented as can be shown in animals. If in the severer infections the development is retarded and the course mitigated very much has been gained.

Practically all the tetanus toxin is rapidly carried along the nerves of the muscles to the spinal cord where it becomes firmly anchored to the cells of the anterior horns.

The period of incubation in tetanus is a variable one, in some cases only several hours. In a general way it is true that the shorter the period of incubation, the more

severe will be the attack, and the more hopeless the prognosis. All cases with an incubation period of less than 8-10 days have an unfavorable prognosis (mortality 80-90 per cent), and are not influenced much by the serum treatment. Incubations beyond the second week permit a more hopeful aspect of cases (mortality reduced from 70 to 40 per cent).

The subcutaneous injection is good, the intravenous is better; best of all is the intraspinal injection. Narcosis is necessary. After about 15 c. c. of fluid have been permitted to flow out, the injection is made very slowly after which the patient is placed in a position to permit diffusion to the upper part of the canal. The dose and its repetition must be left to the judgment of the attending physician.

The immediate cessation of the spasms does not occur and can not be expected because the serum can only take care of the toxin that reaches the parts after the injection. The toxin already anchored is not affected. Spasms must be treated in a general way. This treatment (narcosis, morphine, chloral) is of much importance because patients that do not die from spasm of the glottis or diaphragm, die from exhaustion.

The local treatment of the wound is surgical. Liberal use of carbolic acid is to be recommended.

T. T.

BILE SECRETION.

Ignatowski and Monosohn: Effect of Some Diets and Medicines on the Secretion of Bile. *Ztsch. f. exper. Path. u. Ther.*, Band 16, Heft 2.

Studies were conducted on a male with an artificial gall-bladder fistula. On a liberal diet the secretion of bile reached its maximum much earlier than on a starvation diet, and the quantity was much greater. On a diet of plasmon the quantity of bile was much less than on ordinary diet. 200 grms. of olive oil increased the secretion of the bile but increased only slightly the bilirubin.

Sodium salicylate, however, very effectively increased the secretion of bile and also its bilirubin content. Karlsbader Sprudel (mineral water) decreased bile secretion and bilirubin.

In all cases of liver irritation with its consequent polycholia, and urobilin or bilirubin icterus, one should use Karlsbader Sprudel or similar mineral waters. All remedies of the type of sodium salicylate, cholagogues, are contra-indicated in these cases.

T. T.

INOPERABLE CARCINOMA OF THE UTERUS.

Percy, J. F.: Heat in Inoperable Carcinoma of the Uterus. *Surg., Gyn., and Obst.*, 1914, Vol. XIX, No. 4, p. 452.

The problem in inoperable cancer is, first and most important, to get rid of the gross mass, and second to destroy the progressive metastases. Hot air, steam, hot water, electro coagulation, fulguration and the actual cautery are the agents most commonly employed for the purpose. Hot water, hot air and steam penetrate so slightly as to be of no value. The apparatus required for electro coagulation and fulguration is expensive and complicated and its successful use demands a high degree of specialized training and judgment.

Percy uses local heat from an electric cautery which is absolutely controlled by a rheostat. It is most important that a low degree of heat be used. Cancer cells are destroyed when the temperature in the mass is raised from 122° to 131.9° F., while normal tissues are not injured until the temperature exceeds 131° F. The heating iron, therefore, should never be so hot that the mass goes to 131° F. This low degree of heat does not burn or carbonize the cancerous mass.

A water cooled vaginal speculum is used. The heating iron should not be hot enough to scorch a cotton pledget, even if laid on the iron for some time. An application of from ten to twenty minutes is sufficient. No

smoke or smell of burning tissue should result.

With this method not only is there no destruction of normal tissue but there is also a great penetration of heat throughout the carcinoma cells and a resultant great destruction of them.

This method has been used by the writer not only in inoperable cases but also in certain operable cases as a preliminary for operation. The statistics of his results will be published in a future paper.

G. R. H.

THE RESULTS OF OPERATION FOR UTERINE CANCER.

Wilson, Thomas: The Results of Radical Operative Treatment of Cancer of the Uterus. Surg., Gyn., and Obst., 1914, Vol. XIX, No. 4, p. 456.

The paper is opened by a resume of the history of the operative treatment for uterine cancer. In estimating the results of the operative treatments there are many difficulties. Naturally there are many variations in the work of different operators and also patients react in different ways to the disease.

Wilson has analyzed his cases in the Birmingham (England) General Hospital from 1896 to December 31, 1913, and presents the results of his work.

There were 67 cases of cancer involving the body of the uterus. Forty-three of these cases were operable. There were 50 cases seen at least five years before the time of this study. Sixty-two per cent of them were operable. Operative mortality was 6.4 per cent. Absolute cures attained in 24 per cent.

Cancer of the cervix was found in 529 patients. The ratio of operability has steadily increased from year to year. From 1896 to 1905 it was 18 per cent of 246 cases. From 1910 to 1913 it was 36.4 per cent of 129 cases.

The ratio of absolute cure has also increased from year to year, having risen from 5.5 per cent to 10.2 per cent.

Vaginal hysterectomy for cervical cancer has been performed 52 times. The absolute

curability is 5.5 per cent. Abdominal hysterectomy has been performed 32 times with an absolute curability of 10.2 per cent. All of these reported cases have been observed at least five years after operation.

Wilson states that the results of operative work are constantly improving and may be expected to do so in the future. The immediate mortality of the more extensive operation for cancer of the cervix is also steadily decreasing.

G. R. H.

RECURRENT BRONCHITIS.

Kerley, Charles Gilmore: Recurrent Bronchitis in Children. Archives of Pediatrics, Oct., 1914, Vol. XXXI, p. 741.

With the advent of autumn certain children invariably become sufferers from colds, bronchitis and coughs of an asthmatic type. These cases are to be differentiated from infectious colds, bronchitis, influenza and such disorders as are accompanied by fever, prostration and loss of appetite.

These cases are similar to other periodic illnesses, such as recurrent vomiting, recurrent periodic fever with acetonuria and recurrent eczema, and are encountered more frequently in the colder months since then elimination by the skin is less active and muscular exercise is more in abeyance. Cases of bronchitis of this type are due to a systemic intoxication from the use of certain food substances which the organism is incapable of taking care of. Children suffering from these recurrent affections show a limited capacity for the oxidation of high carbon foods, which, owing to faulty metabolic processes produce an unusual irritability of the respiratory tract.

Since butter fat and sugar are the most frequently abused of the high carbon foods, a patient suffering from recurrent bronchitis shows gratifying relief when these substances are largely removed from the diet. The author believes that the average child after the sixth year receives two or three times as much energy producing food as he requires, and that in many cases both

cow's milk and sugar can be totally dispensed with to advantage. In the treatment of these cases of recurrent bronchitis the patient is cut off largely or completely from sugar and cow's milk, the needed carbohydrates and fats being secured from vegetables, cereals, breadstuffs and meats. Medium-weight underclothing of linen mesh is advised and a hot bath at bedtime followed by vigorous rubbing or massage. The interval medicinal treatment consists of the employment of bicarbonate of soda alone or with the salicylate of soda.

J. D. L.

SUGAR AND GASTRIC SECRETION.

Sherman, DeWitt H., and Johnes, Harry R.: The Effect of Sugars on the Gastric Secretions in Infants. *Archives of Pediatrics*, Oct., 1914, Vol. XXXI, p. 749.

In a series of cases in which fifteen babies were employed there was tested the effect on the gastric secretions of the three sugars, milk sugar, cane sugar and malt sugar.

Every baby was tested with these three sugars, a six per cent solution in barley water being employed. One hour after a given amount of the sugar solution was ingested the contents of the stomach were withdrawn with a view of determining the amount of the solution that had passed on and the effect produced by the different sugars on gastric secretion.

It was found that milk sugar was passed on more rapidly than either cane or malt sugar (Dextri maltose being employed), but that this last preparation of malt sugar was twice as stimulating to gastric secretion as either cane or milk sugar. A conclusion of practical value is drawn from this latter finding and it is suggested that this fact be remembered when feeding infants with hypersensitive stomachs.

J. D. L.

BOAS-OPPLER BACILLUS.

A Study of the Boas-Oppler Bacillus, Galt, H. M., and Iles, C. C., *Journal of Pathology and Bacteriology*, Vol. XIX, No. 2, p. 239.

In making a study of the Boas-Oppler bacillus, Galt and Iles refer to the first de-

scription of the bacillus by Oppler and Boas in the *Deutsche Med. Wochenschrift*, Leipzig and Berlin, 1895, Bd. XXI, S. 73, who described a large Gram-positive bacillus in gastric contents of patients suffering with carcinoma of the stomach. In the same year Schlesinger and Kaufman in the *Wien Klin. Rundschau*, 1895, Bd. IX, S. 225, found an organism of the same characteristics in nineteen out of twenty cases of carcinoma of the stomach.

Very little work has been done on this organism up to comparatively recent time. The organism is difficult to isolate and cultivate and shows many involution changes in fluid media. These changes are of such nature as to lead the investigators to believe that the organism has either been lost or overgrown by some other contaminating organism. The organism is found in the greatest number in the later stages of the disease when the hydrochloric acid is absent and lactic acid is present. While it is more often found in malignant conditions it may occur in non-malignant cases, such as chronic gastritis but the bacilli are not numerous in the latter cases. The organism does not multiply readily in hydrochloric acid.

The relationship of the Boas-Oppler bacillus to the so-called group of acidophile bacteria is brought out in this article. The organism has been found to produce sufficient acid to destroy most all other organisms. Reference is made to the work of Heinemann and Hefferen published in the *Journal of Infectious Diseases*, Chicago, in 1909, Vol. VI, page 304. These men found as a result of their investigations the Boas-Oppler bacillus to be identical with the organisms in the acidophile group, namely: *B. bulgaricus*, *B. acidophilus*, *B. gastrophilus* and *B. bifidis*. These organisms are spoken of as the long rod group of lactic acid bacilli in contra-distinction to the round or oval forms which produce lactic acid in carbohydrate media. The representative member of the group is *B. bulgaricus* or bacillus of Massol, first described by Grigoroff, in 1905.

The organism has been found to have a very wide distribution and to be the chief factor in the souring of milk.

The morphological characteristics of the *B. bulgaricus* and the Boas-Oppler bacillus were found identical. In cultures the Boas-Oppler bacillus requires a special media, such as whey or media derived from milk product in order not to be killed or inhibited by other organisms. The cultures are planted first in whey and after twelve to twenty-four hours transfer is made to "Nasgar."

Notwithstanding the fact that these organisms produce acid and live in a medium of sufficient acidity to destroy other organisms they prefer a neutral media.

The bacillus is a non-motile, non-sporing organism, with square ends, resembling the bacillus of anthrax. It occurs singly and in filaments of four or more often with angles. Gram's iodine turns the Boas-Oppler bacillus a yellowish-brown while it turns the *Leptothrix* blue.

The organisms in this long rod group of lactic acid bacteria vary according to the composition and reaction of the medium used and the age of the growths. Clubbed, curved, granular and filamentous forms are common in fluid media. Growths on neutral, solid media give more densely stained forms.

In young whey cultures organisms are strongly Gram-positive. In old culture the protoplasm seems to retract within the sheath, leaving long lengths of empty covering which can be mistaken for long Gram negative bacilli. By Neisser's method the organism is metachromatic and polar staining with apparent spore formation. Old cultures transplanted to a neutral medium are quickly followed by a return to the normal shape.

The cultural optimum temperature is given at thirty-seven degrees Centigrade. The organism shows preference for anaerobiosis. The organism forms as much as

three per cent of lactic acid in milk or whey media. It turns the litmus milk a livid pink in three days but later turns a dead white. The growth on "nasgar" is so characteristic as to distinguish them from all other intestinal bacteria. Broth yields only a poor growth. The organism does not produce indol or gas. The organism is easily killed in one-half hour at sixty degrees Centigrade.

Pathogenicity — Subcutaneous injections of two billion Boas-Oppler bacilli in the arm merely gives a slight local reaction. Control injection of *B. bulgaricus* in the same quantity gives a similar reaction. The addition of glucose favors the growth of the organism. The following conclusions are given by Galt and Iles:

"1. Specimens of the Boas-Oppler bacillus were obtained from three definite cases of carcinoma of the stomach; in these cases free hydrochloric acid was absent, and lactic acid present in the stomach contents.

2. Isolation and primary cultivation were effected on special media, and the morphological and cultural characters were compared under standard conditions with those of a known strain of the *B. bulgaricus*.

3. The evidence went to prove that the Boas-Oppler bacillus is identical with the *B. bulgaricus*, and not an organism *sui generis*.

4. True dichotomy was observed in cultures both of the Boas-Oppler and of the *B. bulgaricus*, indicating that another member of the long rod group of lactic acid bacteria, namely, the *B. bifidus* of Tissier, is probably identical with the above organisms.

5. The inference was drawn that in cases of cancer of the stomach it is the absence of hydrochloric acid that allows of the growth of the bacillus, and that the lactic acid is formed as a result of the activity of this organism."

In order to show the comparison between the result of investigation of the Boas-Oppler bacillus by Galt and Iles and those of Heinemann and Hefferan¹ on a study of the

Bacillus bulgaricus, the conclusions drawn from the study of this organism are given below:

"1. *Bacillus bulgaricus* is widely distributed in nature and may be isolated by means of incubation in milk at high temperature and subsequent plating on a medium containing 0.5 per cent glacial acetic acid and two per cent glucose.

2. *B. bulgaricus* occurs normally in human feces, in the feces of cows and horses, also in a variety of sour and aromatic foods, in food for cattle, in normal saliva, in normal gastric juice and in gastric juice when hydrochloric acid is absent, in various fermented milks, in ordinary market milk, and in soil, both manured and not manured.

3. Some bacilli isolated from various fermented milks, the so-called acidophile bacilli found in the intestinal tract of man, the so-called Boas-Oppler bacillus, *B. panis fermentati*, *Streptobacillus lebenis*, an organism sometimes called *Leptothrix buccalis*, and possibly *B. bifidus* of Tissier are identical with *B. bulgaricus*.

4. *B. bulgaricus* grows poorly on the ordinary laboratory media and has therefore probably been frequently overlooked by investigators. Milk or media composed of whey, peptone, and glucose are most favorable.

5. The optimum temperature for growth is about forty-two degrees to forty-four degrees C. The Bulgarian bacillus does not grow at ordinary room temperature.

6. *B. bulgaricus* grows as well under anaerobic as under aerobic conditions.

7. The vitality of the *B. bulgaricus* is readily lost, especially in competition with other bacteria under ordinary conditions.

8. The amount of acid produced in milk by *B. bulgaricus* may reach more than three per cent. The acid produced is composed approximately of six per cent volatile acid and ninety-four per cent lactic acid of the optically inactive variety.

9. The casein and fat in milk are parti-

ally decomposed by the activity of *B. bulgaricus*.

10. The presence of *B. bulgaricus* in normal saliva may be responsible for caries of the teeth, because of its ability to produce large amounts of acid from carbohydrates.

11. The presence of *B. bulgaricus* in human feces after ingestion of milk fermented by this organism can not be considered positive proof of its permanent acclimatization in the digestive tract."

H. H.

¹*Journal of Infectious Diseases*, Chicago, 1909, Vol. VI.

NEW AND NON-OFFICIAL REMEDIES.

Since publication of New and Non-official Remedies, 1914, and of the supplement to New and Non-official Remedies, 1914 (July 1, 1914) the following articles have been accepted for inclusion with "N. N. R.":

Abbott Alkaloidal Co.:

Strepto-Bacterin (human: packages of 6 ampoules each containing 100 million killed bacteria; Slee's Normal Horse Serum, vials containing 100 c. c.

A. M. Alexander and Co.:

Typhoid Vaccine.

Antiseptic Supply Co.:

Stypstick Applicators, Alum 75 per cent.

Arlington Chemical Co.:

Arlco Urease.

The Bayer Company, Inc.:

Cymarin, Tablets Cymarin, Ampoules Cymarin Solution.

Fougera and Co.:

Electrargol for Injection, 10 c. c. ampoules.

Greeley Laboratories, Inc.:

Acne Vaccine, packages of 6 syringes each containing 12 million bacteria; Colon Vaccine, packages of 6 syringes each containing 1,000 million bacteria; Pyocyanaceous Vaccine, packages of 6 syringes each containing 1,000 million bacteria; Gonococcus Vaccine, packages of 6 syr-

inges each containing 500 million bacteria. Pneumococcus Vaccine, packages of 6 syringes each containing 500 million bacteria; Staphylococcus Albus Vaccine, packages of 6 syringes each containing 1,000 million bacteria; Staphylococcus Aureus Vaccine, packages of 6 syringes each containing 1,000 million bacteria; Streptococcus Vaccine, packages of 6 syringes each containing 500 million bacteria; Typhoid Bacillus Vaccine, packages of 6 syringes containing 1,000 million bacteria, packages of 6 syringes containing respectively 100, 200, 400, 600, 800 and 1,000 million bacteria.

Hynson, Westcott and Co.:

Urease-Dunning.

Maltine Co.:

Maltine Malt Soup Extract.

Memorial Institute:

Diphtheria Antitoxin, 10,000 units.

H. K. Mulford Co.:

Friable Tablets of Emetine Hydrochloride, Hypodermic Tablets of Emetine Hydrochloride, Antidysenteric Serum, in vials containing 50 c. c., Antipneumococcic Serum, Polyvalent, syringes containing 20 c. c. and vials containing 50 c. c.; Antistreptococcic Serum, Polyvalent, vials containing 50 c. c.; Antistreptococcic Serum, Scarlatinal, Polyvalent, vials containing 50 c. c.; Pyocyano Bacterin, packages of 4 syringes containing 50, 100, 200 and 400 million killed bacteria; Typho-Serobacterin Mulford, Immunizing, syringes containing 1,000, 2,000, and 2,000 million killed sensitized typhoid bacilli.

Pasteur Institute of St. Louis:

Antirabic Vaccine.

Schieffelin and Co.:

Acne Vaccine, packages of 4 syringes containing respectively 5, 10, 20 and 40 million B. acne; Antimeningococcus Serum, 30 c. c. cylinder, 20 c. c. vial; Colon Vaccine, 2 vial packages containing 50, 100, 200 and 400 million killed bacteria; Gonococcus Vaccine, 5 syringes contain-

ing respectively 50, 100, 200, 400 and 1,200 million killed bacteria; Scarlet Fever Treatment, packages of 4 vials containing 50, 100, 200 and 400 million killed bacteria; Typhoid Combined Vaccine (Prophylactic), vials and syringes containing three doses, 500 million killed typhoid bacilli and 250 million killed paratyphoid bacilli A and 250 million killed paratyphoid bacilli B, while the second and third dose each contain 1,000 million killed typhoid bacilli and 500 million each of killed paratyphoid bacilli A and B.

Standard Chemical Co.:

Radium Bromide.

Waukesha Health Products Co.:

Hepco Flour, Hepco Dodgers, Hepco Crits.

HYPODERMIC TABLETS OF EMETINE HYDROCHLORIDE, MULFORD.—Each tablet contains emetine hydrochloride, 0.016 gm. H. K. Mulford Co., Philadelphia (*Jour. A. M. A.*, Oct. 3, 1913, p. 1204).

ACNE VACCINE.—Marketed in boxes of 4 syringes containing 25, 50, 100 and 200 million killed bacilli. Also in boxes of 2 syringes containing 50 and 200 million killed bacilli; boxes of 6 ampoules containing 10, 25, 50, 100, 200 and 500 million killed bacilli, with a syringe; and boxes of 2 ampoules containing 50 and 200 million killed bacilli, with a syringe. E. R. Squibb and Sons, New York.

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GONOCOCCUS VACCINE.—Marketed in boxes of 4 syringes containing 100, 200 and 500 million killed gonococci. Also in boxes of 2 syringes containing 100 and 500 million killed gonococci; boxes of 6 ampoules containing 50, 100, 150, 350, 500 and 1,000 million killed gonococci, with a syringe; and boxes of 2 ampoules containing 100 and 500 million killed gonococci, with a syringe. E. R. Squibb and Sons, New York (*Jour. A. M. A.*, Oct. 3, 1914, p. 1204).

MENINGOCOCCUS VACCINE, CURATIVE.—Marketed in boxes of 4 syringes containing 100, 200, 400 and 500 million killed meningococci. Also in boxes of 2 syringes containing 100 and 500 million killed meningococci; boxes of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed meningococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed meningococci, with a syringe. E. R. Squibb and Sons, New York.

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STAPHYLO-ACNE VACCINE.—Marketed in boxes of 4 syringes containing 100 million killed staphylococci and 25 million killed acne bacilli, 200 million killed staphylococci and 50 million acne bacilli, 400 million killed staphylococci and 100 million killed acne

bacilli, and 500 million killed staphylococci and 200 million killed acne bacilli; boxes of 2 syringes containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million killed staphylococci and 200 million killed acne bacilli; boxes of 2 ampoules containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million killed staphylococci and 200 million killed acne bacilli, with a syringe. E. R. Squibb and Sons, New York.

STAPHYLOCOCCUS VACCINE.—Marketed in boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed staphylococci; also in boxes of 2 syringes containing 100 and 500 million killed staphylococci; boxes of 6 ampoules containing 100, 250, 500, 500, 1,000 and 2,000 million killed staphylococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed staphylococci, with a syringe. E. R. Squibb and Sons, New York.

ANTIDYSENTERIC SERUM.—Marketed in vials containing 5 c. c. H. K. Mulford Co., Philadelphia, Pa.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, January, 1915

Number 7

ORIGINAL ARTICLES

SYPHILIS OF THE INNOCENT.*

J. L. KIRBY-SMITH, M. D.,
Jacksonville, Fla.

Your Association honored me by having me read a paper on this subject at your last annual meeting, and in accepting an invitation to appear before you again, I have this time chosen as the title of my address "Syphilis of the Innocent," and trust that I will not bore you by again reviewing the subject of syphilis generally, and if you do not get anything of particular value from my efforts, other than a bit of my enthusiasm and stimulus for a few new thoughts I will feel that I have been fully repaid.

In an address of this character it would not be amiss to consider the historical aspect of syphilis, and in turn dwell for a short time on the disease itself; by so doing it can be seen why the subject of this paper, "Syphilis of the Innocent" or "Syphilis Infantum," as it is scientifically known, is of such importance to you as dentists. I will omit from consideration the antiquity of syphilis, as in my last address I tried to show you how the ancients had the disease with them, and how historians endeavored to place the blame of this scourge on America, but it would not be out of place to again mention the near-modern and modern facts concerning this disease. It was not until Fracastor in the fifteenth century wrote his famous poem, "Syphilidis sive morbi Gallici," that we came out of the dark ages as far as an understanding of syphilis, or even acquiring our modern name for the disease. After a few hundred years, to be

more exact during 1831-1838, Ricord, a very learned Frenchman, gave us the result of his studies of syphilis, and our real knowledge of the treatment and course of the disease began. Then followed such men as Alfred Fournier and Rudolph Virchow, the former a pupil of Ricord's, who have made a life study of syphilis. Fournier is the author of accepted works on the disease. At this period Neisser discovered the gonococcus as the cause of gonorrhoea, and a little later in 1889 Ducrey discovered that the cause of soft chancre or chancroid was due to a specific microorganism. With these two discoveries the medical man could easily differentiate the various venereal complaints, while up until that time there was no general technique for separating syphilis from ordinary venereal sores. In 1905 Schaudinn and Hoffman independently demonstrated that the spirochaeta pallida is the specific microorganism that produces syphilis. About this time the Wasserman-Neisser-Bruck serum test was so elaborated that blood even from hereditary syphilitics could be shown to contain syphilitic material. Noguchi, a Japanese, in 1911, working in the Rockefeller Institute, found by experimentation that the spirochaeta pallida could be grown outside the human body, and that cultures from syphilitic lesions produced microorganisms which could be inoculated to animals producing syphilis, thus conforming with Koch's law, and proving that the spirochaeta pallida is the true cause of syphilis. At the same time Noguchi prepared a vaccine which can be used in like manner to tuberculin as a diagnostic test for syphilis. Possibly mention should have been made just prior to the work of Noguchi to that of the famous

*Read by invitation before the Florida Dental Association, at Atlantic Beach, Fla., July 3rd, 1914.

Professor Ehrlich in Germany, for in 1910 this man startled the world with his announcement of the cure of syphilis with a new arsenical preparation, Arsenobenzol, a complicated chemical, and better known as "606." Although of great value in the treatment of syphilis, this remedy has fallen far short of the original claims of its discoverer.

Syphilis, like any other infectious disease, has a more or less definite clinical course, and for purposes of description, as well as for treatment or diagnosis is divided into three clinical types or stages. A primary period at which the microorganism is gaining admission into the patient, the inoculation period would better describe this stage, for at the site of the inoculation there develops a more or less hard button-like lesion which is known as the chancre. From this we then have the secondary stage, or the stage of invasion, characterized by numerous constitutional symptoms, varying from a simple eruptive stage like the eruption of German measles, to that of a more violent constitutional infection with fever, loss of weight, and general disability. After a variable time of activity this secondary period may decline, and is followed by a quiescence of several years after which there may be renewed evidence of the infection. This stage is known as the tertiary and it is in this period of the disease that is seen its most damaging effects, all or any of the structures of the body are liable to be involved in destructive or degenerative changes. In an address of this character it would be out of order to go into a detailed account of the symptoms or the descriptions of the various syphilitic lesions that are seen in the three stages of the disease, but briefly we should consider the general characteristics of syphilitic processes. The chancre will occur at the site of the inoculation, no matter where this may be, the organs of generation being the most frequent location, next the lips, and the oral cavity, especially the tongue and the tonsils. As the chancre develops, the ad-

joining lymphatics become enlarged, and after a varying time, from three to ten weeks or longer, constitutional symptoms show themselves. There is a general enlargement of the lymphatics over the body, possibly headaches, bone pains, sore throat, fever, loss of hair, body weight, and appetite, and a general eruption over the body of a definite type, spoken of as a macular eruption. The most important symptom of this stage is the occurrence of mucus patches in the mouth of the patient, these patches occurring with constancy, and are not only the source of importance to the physician in a diagnosis, but are as well the source of infection to others. The eruptive stage as previously mentioned is the secondary, and in it we have clinically several types of skin lesions, each one being such that those who are experienced can make a diagnosis of syphilis without resorting to the Wasserman test. The eruption may be limited, or it may be generally distributed over the body.

Tertiary syphilis is occasionally diagnosed with great difficulty but when the lesions involve the outside structures of the body, the skin or the mucus membrane for instance, the matter of a diagnosis presents little difficulty.

In your field of work as dentists, every stage of syphilis is encountered, the chancre, the mucus patch, and the late or tertiary ulcerations of the disease, gummatous lesions as they are called, either involving the bones of the oral cavity or the structures therein. It can truly be said that the mouth contains a storehouse of knowledge when it comes to diagnosing syphilitic infections.

"Syphilis of the Innocent" is a subject that covers a vast amount of territory, one that is of interest to all mankind, professional or otherwise, and is especially important at this time in sociological studies. It is true that syphilis is ordinarily a venereal disease, and of great proportions. The point that I wish to make is the fact that outside

of the venereal aspect of the disease there still remains, unfortunately, "syphilis insontium."

All medical men are cognizant of the fact that a vast number of people have syphilitic infections. Various estimations have been made as to the probable percentage of such infections. In cities, especially the continental cities, Paris in particular, it is very high. Alfred Fournier, the great French syphilographer, has been quoted as stating that from his treatment of several thousands of syphilitics, and from statistical study of the disease, there is no doubt that the percentage of syphilitics in the population of Paris is fully 25 per cent. This is no doubt a higher percentage than in any of our American cities, but placing the percentage of infections in our cities at from 5 to 15 per cent would not be far wrong. Can one wonder at the frequency of accidental, or innocent syphilis? No doubt the disease is usually contracted through sexual congress with prostitutes, but it is not difficult to see the possibilities of other means of spreading the disease. Fully 8 per cent of chancres are extra-genital, occurring at other parts of the body than the genital organs. The innocent wife, the sister, the fiance or the close associates of the syphilitic are ready means of the spreading of innocent syphilis, the general public through the common drinking cup, or any apparatus or instrument that may come into contact with the infected is a medium of contagion; the barber's shop, the dentist's office, the doctor's office. Syphilis is one of the few hereditary diseases. The new-born baby of the syphilitic parents, if it survive the first few days of its existence, is a menace to all its associates.

At the present time I have under my care a gentleman who developed syphilis from playing with the child of a friend, a slight wound from a pin in the clothes of the infant producing a chancre, and the resulting chain of symptoms being recognized by the family physician as syphilis. Extra-genital

chancres, or true non-venereal sores, occur as previously mentioned at any part of the body, and they are caused through the medium of various things. Chancres sometimes follow surgical wounds, the spirochaeta either gaining admission to the wound at the time of the operation or at a later period, they have been known to originate in the offices of dentists, either through syphilis of the dentist himself or through his instruments, the infection being carried from another patient with syphilitic ulcerations in his mouth. It would be futile to try to give the various ways by which extra-genital chancres arise, the various locations of these lesions or the various percentages of occurrence. In my own experience as a specialist in this line of work I have seen chancres on almost every part of the body; a lady with a tonsillar chancre following kisses with her fiancé, a clerk with a lip chancre due to handling dirty money in a turpentine camp store, physicians with finger chancres following simple needle wounds, a wet nurse with a nipple chancre following the nursing of a baby with mucus patches. You can readily see that it would be impossible to enumerate the different ways in which syphilis can be contracted by the innocent, and it is from this phase of the disease that the most malignant cases sometimes develop, the early lesion is possibly not recognized, and the resulting secondaries may be very obscure, in fact it is not at all uncommon for patients to pass through the first two stages of syphilis without being cognizant of the fact that they are infected, and are only aware of the disease when some of the late manifestations of the tertiary stage show themselves, scarcely believing the verdict of their physician consulted after having been suddenly stricken with some grave deviation in his health.

It has been asked, will the new treatment for syphilis lessen the frequency of the occurrence of the disease? Certainly at this time there must be felt some benefit from Ehrlich's discovery, especially when one con-

siders the rapidity with which syphilitic lesions disappear after an intravenous injection of salvarsan. An actively infectious patient is rendered free of infection to his associates after a few days. In the writer's opinion the ultimate result of this intense method of treatment will as a whole decrease the number of syphilitics temporarily, but after a few years the number of innocent infections will be greatly increased. To explain this statement it will be necessary for you to understand that Arsenobenzol (606) is being used by the medical profession very indiscriminately, patients are daily being lead to believe that one or two, or a few, injections of "606" or the newer preparation "614" in the course of a few weeks' time will give them a permanent cure, and seemingly they are cured—they feel fine, have no symptoms of their disease, possibly the blood test has been resorted to, and the report shows that the patient is apparently free from infection. Experience is showing us today that patients treated four years ago in this haphazard way are now showing up with active lesions of syphilis. What results from this? A vast number of people are led to believe that their future is safe as regards their syphilitic infection—they enter matrimony with a clear conscience, they pass around among you with recurring sores in their mouths, their children, if they are so unfortunate as to have any, are born either with syphilitic lesions present, or with the taint of the disease in their blood. Syphilographers now as in the past assure their patients that they can be cured of syphilis, but not by a few injections of salvarsan in the space of a few weeks, but by several injections in the first year of the disease, as well giving them thorough mercurial treatment during this time and continuing this for a year or more, and then having blood tests made at intervals to ascertain if the cure is permanent.

From your standpoint as dentists, syphilis of the innocent is most important. How shall you protect yourselves, and how shall

you protect your patients? First of great importance to you is that you are able to recognize syphilitic lesions when you see them; you should be able to tell a mucus patch at first sight. No doubt there are syphilitics who seek treatment in your office that are not aware of the existence of lesions in their mouths; then, too, there are those who do not even know that they have syphilis and they, too, carry around the infection, and lastly those who know they have lesions in their mouth and do not care. You should have very little trouble recognizing the hereditary syphilitic by the teeth, the formation of the bones of the mouth and the scars in the mucosa. All cases of ulceration of the tongue or of the mucus membrane of the mouth of those of young or middle age should be looked upon with suspicion. It is true tuberculosis and cancer are possible, but they are both relatively uncommon. It is better to error on the right side than to take a chance at being exact in your diagnosis.

In the treatment of syphilis with mercury it is absolutely necessary that the teeth of the patient be in good order, and the action of mercury is such that all patients will sometime in the course of treatment require dental work, and it should be the duty of the physician to notify the dentist of the patient's condition should he have syphilitic lesions in his mouth. What shall you do to protect yourself and patients? The old adage, "An ounce of prevention is worth a pound of cure," will fit your case best—thorough sterilization of those instruments that come into contact with the secretions from the mouth of suspected patients, and your own hands as well. I am sure you dentists have been taught the technique of sterilization as thoroughly as we physicians, but the trouble with both of us is we sometimes get careless; in your case, especially you who have an extensive practice, will no doubt think it an added hardship to sterilize properly every instrument, after every treatment, but certainly you should carry this out

after having treated any patient with the least suspicious lesion in his mouth. Look upon all of these cases as syphilitics, and even though they are not, you will not have hurt the feelings of any one.

DIRECTIONS.*

U. S. BIRD, M. D.,
Tampa, Florida.

The old gag about the patient's interpretation of the directions, "Shake well before taking," is probably neither a joke nor an exaggeration. It serves to illustrate an important detail in practice: the giving of directions. It may seem that when a doctor has taxed the resources of his medical equipment in evolving a therapeutic, chemical, palatable and esthetic preparation; one that shall be efficient, safe and pleasant, that he has about met all of a rather rigid set of requirements which are not easy to meet. Safety is of the first importance. A professor of therapeutics used to caution his classes never to write a prescription for a dangerous quantity of any drug. That is a good rule to remember, but difficult to follow. I know an eye man who uses atropin in his office only, fearing to prescribe it for the patient's use. Every physician must decide for himself what is advisable, the permitted latitude varying with conditions.

The considerations of palatability and pleasing appearance, while probably of less importance from the patient's interests, are scarcely less so from the doctor's, as inattention to these details may be a question, not of life but of business. To the nauseating mixtures, compounds, emulsions, suspensions, confections, electuaries and the like of old allopathic days do we owe the inception of homeopathy, the peculiar medical products of which have at least the virtue of not being repulsive; a detail which has been extensively and profitably capitalized.

Granting that the structural requirements of modern, scientific prescription writing have been met, we may then consider another important detail: the directions. It appears impossible that directions could be misunderstood to the degree that they not infrequently are. Before losing patience it may be well to consider the relations of the parties to the directions. The physician is not always innocent of neglecting to do his part. It is impossible to be too carefully exact in giving directions. The use of a word of doubtful meaning or even the lack of proper emphasis may result in much unhappiness for both patient and physician. At times all of us have had to depend on extemporaneous road directions. After giving an exhausting audience to a lecture on rural orientation we have started hopefully, only to be hopelessly lost in the first half mile. The laboriously delivered directions failed to allow for a fork, the significance of which had escaped the speaker. For a long time this often observed phenomenon was a psychological puzzle to me. I finally solved it to my own satisfaction by assuming that an intimate familiarity with any concrete subject, in this instance a road, included a subconscious, automatic knowledge only, of many details; such details really being non-existent, in the sense that for the moment they are not actively, sensibly perceived. Hence the important omissions in the well-meant directions. An analogy may be recognized in medical directions. The physician, entirely familiar with the conditions and the prescription, may easily overlook some apparently unimportant detail, which, to the bewildered patient, is only a part of a vast mystery, full of doubt and danger, without the proper explanation. This mutual misunderstanding may lead to apparently strange and unaccountable results, even to the extent of shaking one's self rather than the bottle, therein being good and sufficient reasons for explicit directions. While in general practice I had a habit of writing out my directions in full, in addition to what

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

was on the label. Office work and personal treatment have broken me of this excellent practice. Occasionally a patient returns explaining how careful he has been to apply the medicine intended for his stomach to his eyes, or that he has continually taken a remedy ordered for one occasion only, and not to be continued unless further directed. Sometimes the directions are understood but the patient decides to use his own judgment. Being relieved by the prescribed dose, he reasons that more will be better, with occasional unfortunate results. The reverse is not uncommon, especially in luetic conditions. Then again is the unpleasant experience with the attendant who is inclined to assume the physician's prerogative, and interpret the directions accordingly, using some ambiguity as an excuse. In such case it is particularly desirable that cautious and explicit directions be given, avoiding inaccurate and obscure terms.

My purpose will not be better served by a multiplication of details. It is hoped that the importance of this part of our work, both to patient and physician, will justify these few minutes of discussion in emphasizing an active realization of a fact which, in whole or in part, is liable at times to be relegated to the realm of subconsciousness.

THE CHARACTER OF INFANT STOOLS.

Some information that can be obtained from Macroscopic Inspection.

WALTER C. PAGE, PH. G., M. D.,
Live Oak, Fla.

1. The character of the stools, not the quantity denotes disease.

2. The normal stools of a healthy infant are yellow in color, are smooth and about the consistency of butter, they should contain no curds or lumpy masses, no mucus that can be seen by the naked eye, the reaction may be slightly acid, neutral, or slightly alkaline, but should not be very strongly acid or alkaline.

A good rule to use is, when the stools are slightly acid the color is of a brownish nature, when the reaction is alkaline the color leans towards green.

3. When the stools are white or greyish, and are solid or of lumpy consistency, it is usually an indication of a deficiency of bile, or bile salts. Such condition is due to an excess of undigested fats, which owing to the lack of bile are not saponified and absorbed; stools like this are slightly acid in reaction, and is the stool of intestinal indigestion.

4. Black, tarry, sticky stools point to a hemorrhagic condition, the presence somewhere of a bleeding focus in the intestines, usually in the upper digestive tract; stools like this are seen in acute gastritis and acute gastroenteritis, and it is a mighty bad sign, too.

5. Stools, light brown or of greenish color, and of liquid consistency are almost always the result of a violent infection of the intestinal tract of microbic origin, indeed it is a sign of true intestinal infection.

6. Diarrhoea may be caused by organic acids, and the alkaloids formed by microbic industry; a simple diarrhoea may be provoked by an irritant action of these acids, the body promptly makes an effort to render the stools alkaline and thus neutralize these acids.

7. The more serious forms of diarrhoea, such as those that come on sudden, violent and serious are mostly due to the presence in the intestines of the dangerous alkaloids of microbic elaboration, ptomaines, etc.; in the early part of such an infection the stools may be green, later they may become light dirty brown, and as they approach to normal and the patient improves the stools will gradually take on their normal yellow color.

8. After a long siege of gastroenteritis, when the stools are colorless, and completely liquid (the so-called rice-water stool), the patient is in a state of extreme infective diarrhoea, and the pigment substances are

no longer available to color the stools, nothing remains but the alkaloids that are produced by the infecting organisms, and the body fluids of the little patient.

9. As to feeding after a case of diarrhoea of microbic origin—Young's sign: watch the stools carefully, and when you see in them small bright yellow particles that glisten and adhere to the sides of the vessel, they may not be any larger than the point of a pin, you may know that the secretions of the intestinal tract have started up again, and you can begin to feed the patient a little, but then extreme care must be exercised for quite a while, at least no milk or solid particle should be given at all until these little particles appear in the stools.

REPORT OF HUMAN CASE OF GLANDERS.*

LEON ASHLEY PEEK, M. D.,
West Palm Beach, Fla.

B. W., mulatto man, 30 years old, 6 feet 1½ inches tall, weighing ordinarily 230 pounds, wheel chair man, very strong and in vigorous health, personally known to me for three years before coming under my treatment as related below, married, with several healthy children. Came to me on May 31st, 1913, with a severe infection of the left index finger, looking like a neglected carbuncle with extensions up the finger, and on back of hand. Several places where pus could not come out easily were opened. He was treated with ordinary antiseptic applications, and given antistreptococci serum. Glands in axilla were affected, there was a spot below the elbow beginning to rise, and also one on his right leg.

For three days he was given 20 c. c. Mulford's antistreptococcic serum daily, and large doses of lactate iron internally with vigorous local treatment. There was no improvement. History was that he had been

bitten by a horse three weeks earlier. I then asked to see the horse that had bitten him, thinking I might find a glandered animal. Sure enough it was typical glanders clinically in the horse.

I told him what was the matter, and reported the human and the animal case to the Florida State Board of Health. Unfortunately B. W. did not remain under my treatment at that time.

On June 8, 1913, Dr. W. A. Munsell, of Green Cove Springs, Assistant State Veterinarian, came to see me about my glanders cases. I took him to see the horse, the man having left town. He tested it according to the most approved manner with mallein, and got a positive reaction, and told me to see about having the animal killed and buried, which I did. He did not see the man.

On August 17, 1913, B. W. came under my treatment again, having meanwhile been in Jacksonville and I do not know where else under varied treatment. I told him that the only treatment was to get a suitable vaccine, and I began hunting for it. I sent first to Mulford, who stated that they could not furnish anything suitable, and neither the various manufacturers nor the State Board of Health of Florida could help me out at all with my glanders case in the way of appropriate vaccine treatment. I wrote to Dr. Wm. H. Park, of New York; receiving no reply to my request for information where to obtain vaccine for this case, I telegraphed him, and got an immediate reply saying "City Health Department furnishes vaccine, send me particulars of the case." In due course of time I got the vaccine, and before beginning its use I sent a specimen of blood from the case to the Division of Laboratories of the City Health Department, New York City, who reported a positive agglutination test for glanders.

Glanders vaccine furnished me was 20 c. c. in amount, each c. c. containing .2 mg. bacteria killed by heating to 70 C. for two hours.

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

On September 21st, 1913, I gave B. W. four minims of this vaccine in upper arm, at 9 a. m. At 5 p. m., same day, his temperature was 99.4, complained of arm being very sore, and a feeling of tightness. No visible change at that time.

September 22nd, 9 a. m., temperature 99.4, vaccinated spot swollen and painful about two inches in diameter.

Same day, 5 p. m., temperature 100.4, arm too sore to use, very large inflamed space, and general soreness and aching all over body.

September 23rd, morning, still very much pain in arm.

September 24th, morning, arm hot to touch, swollen and sore.

September 25th, morning, arm still sore. Gave him two minims glanders vaccine in left flank.

September 29th, gave him three minims vaccine, arm place nearly gone, flank place quite sore and swollen, gave this dose on other flank.

October 5th, gave three minims vaccine. After last injection the earlier places became very sore.

October 9th, gave four minims.

October 14th, gave three and a half minims.

October 19th, gave him five minims; improving in health now, not noticeable before today. Sores distinctly better, the ulcers having a clean granulating surface and healing edges.

October 23rd, gave five minims, very apparent improvement in general health and especially notable healing of ulcerated spots.

November 1st, gave five minims.

This was the last time I gave the patient any of the vaccine. I had plenty more, and had been promised all I needed free, but the African ancestry of my patient asserted itself at this moment. He was getting well, therefore he did not think he needed any more treatment.

I am very much disgusted with the way treatment was followed by this individual, but you all know the genus homo Africanus.

December 19th, 1913, Dr. Heck, connected with the Florida State Board of Health, visited me on other business and I took him out to see B. W. He was at that time very much better. When he began vaccine treatment he weighed 170 pounds; at the end of treatment, November 1st, weighed 198 pounds, now weighs 212 pounds, and all his sores nearly healed.

March 28th, 1914, B. W. came to my office at request of his employer who was thinking of taking him north to attend him during summer. He weighed 220, and looked perfectly well. The sores were all healed. There were, however, several subcutaneous nodules on arm, and in axilla, and from one of these I squeezed a small drop of pus. I told him that he was not well, and that there was no doubt he would completely recover if he would continue taking the vaccine for a time. He promised to do so. I have not seen him since. I understand that his employer took him north as a personal attendant, against my advice.

I have no doubt that I would have had a perfect result in this case if it had been manageable. I think that he will go on very well as long as his work is light and his food plentiful, but when he gets sick with an intercurrent affection, or when he gets out of work and on short rations, the disease will manifest itself.

Human cases of glanders should be taken in charge by the public health authorities, and treated by force until they either get well or die. Horses when infected are killed. From my experience with this case, I believe that human cases should always get the benefit of the vaccine treatment. Valuable animals also should be given the benefit of treatment before destruction.

[AUTHOR'S NOTE—On January 7th, 1915, patient apparently perfectly well. He is doing his regular work this winter as a wheel chair man at Palm Beach, free from all nodules and has only a few scars in evidence of the infection.]

THE TREATMENT OF DRUG ADDICTIONS.*

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Jacksonville, Fla.

In taking up this subject I well know the public feeling and the professional antipathy that exists against all so-called Institutes and cures for drug and alcoholic addictions and two years ago I did not expect ever to be interested in this subject. I ask the indulgence of those who are not interested, for the time taken up. In the capacity of City Physician of Jacksonville I was brought into direct contact with these poor unfortunates, have seen the amount of damage done and the number of drug fiends we have in our city, am sure we are not alone, as all cities of any size have them and I am satisfied the number of habitues are fast increasing. The subject is now being taken up by health authorities and medical societies the world over and efforts are being made to restrict the traffic by advocating government control of habit-forming drugs.

I wish to go on record as refuting the idea that the physician, in the majority of cases, is responsible for this habit, for I do not believe they are responsible for 10 per cent of the cases and will cite a few figures which I think bear out my refutation. Out of 167 cases coming under my personal observation, 102 or 67 per cent used only cocaine by insufflation or sniffing; 25 or 14 per cent used morphine only, of these several admitted that friends, habitues themselves, had suggested the use of the drug (morphine cases are the ones I grant are most likely formed by the physician); 11 or 7 per cent used tincture of opium; 20 or 12 per cent morphine and cocaine hypodermically; 2 or 1.2 per cent used gum opium; 2 or 1.1 per cent used heroin, while cocaine and tincture of opium, cocaine, morphine and tincture of opium, morphine and atropine,

hyoscine, morphine and cactin each claim an habitue. In the series of cases 49 per cent were colored females, 24 per cent white females, 17 per cent colored males and 10 per cent white males. The records of the department of health of Jacksonville show a total of 887 habitual drug users in 1913, or 1.31 per cent of our population.

The problems that present themselves to us are the control of habit-forming drugs with a view of preventing accessions to the ranks of habitues and the treatment of those already addicted to their use. The former can only be handled through the control of these drugs by our national government, while the latter, the treatment of habitues, should be under the supervision of state, county and municipal governments, it of course being the duty of every physician to co-operate with the authorities to the fullest extent possible. It must be admitted that the work is very discouraging when we see cases successfully treated only to return to the drug with the very first ailment they may have, but when we see a few wrecks saved, even if they do form a small per cent, is it not worth while? Are we not repaid? There is no class of patients who respond so rapidly as these when they are carefully treated. When I first undertook to treat these cases I had no definite line of treatment, nor could I find many authorities to consult as there is little literature on the subject. I consequently made errors and lost valuable time in instituting treatment in my first few cases. I demonstrated with cocaine addicts that they did not have any of those disagreeable symptoms when the drug was withdrawn as is the case with those using other drugs, especially morphine, and I also found that 20 grains of morphine per day would give as much relief and satisfy a patient as would a drachm, I therefore adopted the gradual reduction method.

Upon admission the patient is stripped of all clothing, given a hot bath and clothed in the regulation prison garb, this to prevent any chances of secreting the drug. We then

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ascertain the amount of the drug used per day and the method of taking it. If a heavy user, that is taking above 10 grains per day, the patient is given frequent small doses, the total quantity for 24 hours not exceeding four grains. Following this routine, diarrhoea, suppression of the urine, intestinal cramps, all frequent complications following the sudden withdrawal of the drug, were avoided. The dosage and frequency of administration is gradually reduced as the patient improves and in no case is the drug continued over a period exceeding two or three weeks. Further treatment consists of efforts to determine, and if possible correct, any pathological process that may have been the original cause for the creation of the habit. As a routine phosphorous is given as a tonic.

I have also used with success the belladonna treatment, originally suggested by Mr. Charles B. Town, of New York, who has an international reputation in the treatment of drug habits. The method of treatment is as follows:

The patient is put to bed, given a S. S. enema and later 4 C. C. pills and 5 grains of blue mass. With intestinal elimination complete, half the usual daily dose of drug used is given, this followed with 6 or 8 drops of the following prescription:

Tincture of Belladonna ʒiv.

F. E. Xantheoxylum.

F. E. Hyoscyamus aaʒii.

This is repeated every hour increasing two drops every six hours until 16 drops are being given, then going back to six drops and increasing as before. With the appearance of dilatation of the pupils, dry throat, red rash, or quick staccato voice, suspend treatment until these symptoms disappear, when treatment should be again resumed. Fourteen hours after commencing treatment the patient is given 4 C. C. pills and five grains of blue mass and this again repeated six hours later. If within a few hours elimination is not complete, 4 C. C. pills and 10 grains of blue mass is adminis-

tered and with purgation complete, one half of the usual amount of the drug used by the patient is given. Twelve hours later the patient is again given 4 C. C. pills and five grains of blue mass, this being followed in six hours with two ounces of castor oil. This completes the treatment. After the patient has been under treatment for 30 hours he should receive 1-30 of a grain of strychnine sulphate every three hours. I have used this line of treatment several times when a nurse was available and obtained splendid results.

Another method of treatment that is worthy of trial is the hyoscine treatment which consists in the administration, after complete purgation, of a 1-100 of a grain of hyoscine hydrobromide, hypodermically every hour until the patient becomes thoroughly under the influence of the drug and then giving just enough of it to hold him so for 48 to 72 hours; the drug is then withdrawn. The treatment is apt to be accompanied by insomnia, cramps, intense sweats and suppression of the urine; these have to be treated symptomatically. In conclusion I would say that we have no guaranteed cure for the treatment of the drug habit. We can only promise by the gradual withdrawal of the drug and by the removal, if possible, of an existing pathological process originally responsible in creating the habit, to relieve this class of patients. We will not attain 100 per cent cures, but we can secure some.

TOXEMIA: SOME POINTS ON ETIOLOGY AND SYMPTOMS, WITH DEDUCTIONS.*

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Food rendered toxic by any artificial preservative will cause toxemia. The symptoms of such toxemia develop so slowly as to be difficult to recognize and trace to their etiological factor. Most of these symptoms

*Read before the forty-first annual meeting of the Florida Medical Association at Orlando, May 13-15, 1914.

consist of marasmus, indigestion, asthma, atony, degeneration and debility. We can state positively that a chronic supply of the salts of tin, lead, copper, alum, borax, etc., will cause these symptoms of mal-nutrition and increased susceptibility to infection.

Food containing toxine or ptomain will produce symptoms of toxemia in such a short time as may be necessary for absorption (as would be the case with a toxic dose of strychnine or alcohol). If this does not cause death in a few hours we have only the danger of debility remaining. Cooking will not destroy all toxines or ptomains.

Food containing living infection, when ingested, may cause infection in the digestive tract; yet by such slow production of toxine or ptomain, symptoms may not be developed for days, weeks, or even months. (We feed babies tubercle infected milk but can not prove they have tuberculosis for from three months to three years.) Cooking will kill infection.

Improper preparation, even without adulteration, of food causes unbalanced diet, toxemia. We have learned that the carefully milled cornmeal may cause pellagra, while cornmeal containing hulls and germs will benefit such cases. Rice, even, when beautifully cleaned, may cause beri-beri—curable by eating rice hulls or bran. Our glorious white American flour has branded us a nation of neurasthenics. One potent beneficial agent in relieving such trouble is the addition of bran and shorts to our diet. This is evidence that unbalanced diet causes unbalanced function toxemia. The food's seeming purity is its defect. Even freezing or boiling modifies food values extremely. Milk, the best animal extract known, adapted to supply every demand of the growing system, when boiled, is removed from its natural grade, *all-sufficient* to the class *deficient*.

Toxemia as a result of infection is generally loosely divided under the heads, acute and chronic. In the acute class the toxines are very soluble and rapidly absorbed as

typified by tetanus, diphtheria pest, etc. Here we have typical symptoms produced by the toxemia peculiar to each, except when the system is overwhelmed by extreme intoxication. We then have complete inhibition of all normal function and loss of resistance, resulting in unbalanced cell activity, giving us septic auto-intoxication. This may occur even in malaria, meningitis, scarlet fever or mixed infection. In this stage we lose our typical disease symptoms and may mistake any of the class for typhoid. Here the history should prevent error.

Chronic toxemia only modifies normal function. When complications occur we find tissue destruction, *e. g.*, pellagra. Symptoms called rheumatism, eczema, benign endocarditis, even mental aberration, dropsy, epilepsy, neurasthenia, hysteria, etc., may have their etiological factor in infected sinuses of the head; in decayed teeth; or infection in various parts of the intestinal tract; in the urinary tract, or the skin. Such infection may be bacterial, plasmodial, protozoan, even ordinary worms, including hookworms and flukes. (A very common form of this toxemia caused by parasites in the South, is the fissured tongue.) These symptoms are not found at the point of infection. These toxines may act on secreting glands, giving us secondary auto-intoxication.

Distinctly differing from such toxemia is *local infection*, as malignant endocarditis, arthritis, neuritis, infective dermatitis, etc.

Heat toxemia is well known in the North as insolation, with its overwhelming effect, coma, delirium, convulsions, etc., caused by inhibition of function. In the South we have only chronic heat toxemia with slight modification of function as shown by linear ridges in finger nails; stained or bleached spots on skin; hyper-esthesia, atrophy, etc.

Auto-intoxication can not be limited to unbalance in gland secretions because in the great majority of such cases the predisposing factor may be unbalanced diet, or unsuspected chronic infection or any variety of chronic toxemia, even the unbalance of

heredity. This variety is of especial interest as it simulates many other diseases. Hysteria to mania; blushing to urticaria; anacidity or hyperacidity; constipation or diarrhoea; a tyroid heart or suprarenalin skin; perspiration excessive or absent; temperature varying as much as ten (10) degrees; palpitation, etc. We know anger or grief may change a mother's milk to poison; cause a miscarriage or an attack of jaundice. We know that dis-use causes atrophy; moderation means perfection; excess results in degeneration. These physiological laws explain the necessity of knowing all we are doing when we modify gland function by the use of gland extracts. Here the law of mathematics is at fault and one and one may make one thousand, plus or minus, to benefit or injure.

At present we are glad to get our information on the use of gland extracts and drugs from the meat packer, dye house, chemist, and the drug houses; and we are grateful for the literature they so freely send us.

War and epidemics by demanding immediate action are the crucibles for theory. They diffuse knowledge by publicity.

In time of peace, the charity hospital is our recognized field for clinical opportunity and study. What right have we to use our indigent brother for this study? Why pay to have our condemned criminal killed and waste this good material? Why please the commercial houses by testing their claims on our patients?

Team work by the politicians rules the world. Team work in religious guides the world. The lack of team work in medical science is our deplorable disgrace and handicap.

In 1868 Dr. Nicholas Senn planted epithelioma in his own arm—by good luck without effect. Today we know that some varieties will grow by transplanting. Where cancer is caused by protozoa, we know radium will cure. When blastomycetic, X-ray will cure. Seventy-five per cent

(75%) we send to the surgeon because we do not know their etiology. Team work alone will aid us here.

Our State Health Board should be backed by every licentiate, thus enabling it to enforce preventive measures which are absolutely impossible today. Our government must appoint a commission of scientific medical men, an expert in each and every branch of our work. Commanding the necessary material, and with the continued assistance of the army and navy medical force we can attain the degree of usefulness our science deserves. Such a commission could wipe out all fakes and prevent such crime as planting turtle tuberculosis in human beings for profit. Etiological questions could be settled without the necessity of the average doctor to try them on your baby or mine. They would never be able to replace the individual physician at the bedside where he must study each complication, but they by team work will supply us with definite scientific information—our lack today.

THE EPILEPTIC CHILD.

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The most serious and intractable disease in the whole catalogue of human ailments is unquestionably epilepsy, and it is indeed a sorrowful moment when parents are first brought to a realization of the fact that one of their children is an epileptic; it is even more tragic if to the child's misfortune is added any lack of good judgment on the part of the parents.

Infantile convulsions are often the starting point of a chronic epilepsy, and there is nothing in the type of the convulsion which enables us to determine whether epilepsy is likely to follow or not, only the subsequent history determining this. Apparently chronic epilepsy is most often the result of repeated attacks of convulsions in infancy.

The causes of the convulsions in infancy—pathologic dentition, ascares, rachitis, night

terrors, acute infections, fright, and gastrointestinal disturbances, must exert their influence through some common factor.

Such a factor might be abnormal vaso- and cardio-motor systems with a ready liability to attacks of vagus inhibition.

Infantile convulsions are associated with marked cutaneous vaso-constriction, evidenced by pallor and a sensation of chilliness. The sensitive cardio- and vaso-motor systems of the child may not be able to compensate for the rise in blood pressure thereby induced, and it is to be noted that the old established method of cutting short convulsions in infancy by means of the hot bath, producing a vaso-motor dilatation of the skin, reducing blood pressure, often acts equally well in epileptic attacks.

There are many types of epileptic children, some of whom are unusually clever, and others inordinately stupid, but it must not be forgotten that they are all abnormal.

Among those that are unusually quick-witted and alert it is common to find that their parents permit them to outstrip their schoolmates by way of proving "that there is nothing the matter with my child," but even in the cleverness of such children there is something morbid and ill-balanced, and it is wiser to restrain and quiet them than to let them excite themselves in competition with their fellows.

Some slow-minded epileptic children are nervously conscientious and painstaking. These it is well to watch and encourage, but usually it is best to hold them back in their efforts to keep pace with normal children.

Since the types vary so widely the proper treatment and discipline must vary also, and each child must be dealt with according to his individual peculiarities.

The most usual mistake that parents make is to abandon discipline altogether, and let the child run wild, in the hope that the attacks will occur less often; but they ought to remember that the victim of epilepsy needs, more than most people, the self-con-

trol and the good habits that only wise discipline in early life can establish.

A life that is led in the open air, with some quiet occupation, such as gardening or poultry raising, is a good preparation for adult life and helps to give the long hours of sleep and good digestion that are so necessary.

The care of the digestion is most important in epilepsy. An error in diet is almost certain to bring on an attack and it is usual to find that epileptics have poor digestions. Their food should be simple, and moderate in amount, and it is an excellent plan to establish the habit of slow eating in childhood.

It is an undisputed fact that the largest percentage of cures are made in institutions devoted exclusively to its treatment, and some of these report as high as 10 per cent of cures.

Of these institutions, those on the colony plan are the best, as offering a more home-like life and congenial occupation, and the New York state institution at Sonyea, Craig Colony, is the best example.

THE INFLUENCE OF STARCH ON INFANT DIGESTION.—High fat in breast milk, during the early weeks of nursing, is one of the most prolific causes of gas, spitting up, and loose mucoid stools with flaky curds. Many of these cases are the so-called "colicky" babies, whose mother's milk is condemned as "poor" and the babies weaned when with reasonable understanding of the condition and proper treatment they might readily continue at the breast. Such infants, already disturbed by the more readily digestible fat of breast milk, are not good subjects for the customary formulae of cows' milk commonly employed in bottle feeding, and weaning is liable to bring about a condition worse than the first. Complementary feedings, however, of some starchy gruel, are most useful in the nursing infants for overcoming the bad effects of the high fat percentage, not only when given so as to dilute the breast milk, but occasionally also, as I have knowledge, when the gruel is given by itself only once or twice a day.—Thomas S. Southworth, M. D., in *The Journal of the American Medical Association*.

PROPAGANDA FOR REFORM

AGAR-AGAR BISCUITS.—To make agar-agar biscuits it is only necessary to add finely powdered agar-agar to the flour used in making the biscuit. The amount should be, if possible, sufficient so that a dose of 5 gm. will be contained in each biscuit. (*Jour. A. M. A.*, Oct. 3, 1914, p. 1224.)

ACTION OF SODIUM CACODYLATE.—Containing its arsenic in organic combination and in the pentavalent state, which becomes therapeutically active only as it is reduced to the trivalent inorganic state, sodium cacodylate is so slightly toxic that therapeutic doses do not give rise to toxic symptoms. There is nothing in the literature to show that sodium cacodylate has a special action on the eye and blindness from its administration need not be feared. (*Jour. A. M. A.*, Oct. 3, 1914, p. 1223.)

CELERINA AND ALETIS CORDIAL (RIO CHEMICAL CO.).—Celerina is a shot-gun mixture said to contain, in addition to 42 per cent of alcohol. kola, viburnum, celery, cypripedium, xanthoxylum and aromatics. Aletris Cordial is said to contain 28 per cent alcohol (more than is found in wine), besides three obsolete and valueless drugs, aletris, helonias and scrophularia. Whatever virtue there is in Celerina and Aletris Cordial is derived from the alcohol. (*Jour. A. M. A.*, Oct. 17, 1914, p. 1411.)

DECLARED MISBRANDED.—The Federal authorities have secured convictions under the Food and Drug Act against the following "patent" medicines: Nurito, West Baden Sprudel Water, Radam's Microbe Killer, Dr. Hilton's Specific No. 3, Dr. Sullivan's Sure Solvent, Russell's White Drops. With the exception of the first two the products were declared misbranded chiefly because false and fraudulent therapeutic claims were made for them. Nurito was declared misbranded because false statements in regard to the ingredients were made and West Baden Sprudel Water because it was not a natural water as claimed.

(*Jour. A. M. A.*, Oct. 17, 1914, pp. 1408 and 1409.)

GINSENG.—Despite the fact that the peculiar man-shaped root of ginseng has no medicinal value so far as science can determine, the Koreans for decades paid their tribute to China in ginseng. In China it is reported as a cure for all ills that human flesh is heir to and has a special reputation as an aphrodisiac. Perhaps there is no better illustration of the virtues of aphrodisiacs in general than the fact that the Chinese are quite sure of the marvelous efficacy of ginseng though no evidence of its virtues can be obtained in the West. (*Jour. A. M. A.*, Oct. 24, 1914, p. 1486.)

GLYCOTHYMOLINE REFUSED RECOGNITION.—A report of the Council on Pharmacy and Chemistry cites Glycothymoline as a typical illustration of a "patent medicine" advertised to the public through the doctor. Different formulas have been ascribed to Glycothymoline by its promoters from time to time—but whatever the exact composition of this secret nostrum may be, it has been definitely shown that it is but a weak antiseptic solution. Nevertheless, the advertising circulars recommend the use of Glycothymoline in such serious conditions as diphtheria and ophthalmia of the newborn. Glycothymoline is in conflict with Rules 1 and 4 of the Council on Pharmacy and Chemistry, because of its indefinite composition and the method of advertising it to the public. It is in conflict with Rules 10, 6 and 8, in that it is an unscientific, shot-gun mixture sold under unwarranted therapeutic claims and under a misleading name. (*Jour. A. M. A.*, Oct. 10, 1914, p. 1313.)

PHENOLAX WAFERS.—These are tablets said to contain phenolphthalein 1 gr., "aromatics" and sugar enough to make five grains. It is a question what purpose the "aromatics" and sugar serve, perhaps these are to mislead the unthinking to believe that this combination has some mysterious value over phenolphthalein itself. (*Jour. A. M. A.*, Oct. 17, 1914, p. 1410.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville.
Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association,
St. Augustine, Florida, or 334 St. James Building,
Jacksonville, Fla., U. S. A.

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First District—Escambia, Santa Rosa and Walton
Counties: J. Harris Pierpont, M. D., Pensacola. 1916

Second District—Franklin, Gadsden, Jefferson, Leon,
Liberty and Waukulla Counties: Henry E. Palmer,
M. D., Tallahassee 1917

Third District—Columbia, Hamilton, Madison, Lafay-
ette, Suwanee and Taylor Counties: C. S. Brown,
M. D., Live Oak 1917

Fourth District—Duval, Clay, Nassau and St. Johns
Counties: Gerry R. Holden, M. D., Jacksonville. 1918

Fifth District—Citrus, Hernando, Lake, Marion and
Sumter Counties: H. C. Dozier, M. D., Ocala. 1915

Sixth District—Hillsborough, Pasco and Pinellas Coun-
ties: U. S. Bird, M. D., Tampa. 1915

Seventh District—Brevard, Orange, Osceola, St. Lucie
and Volusia Counties: David Forster, M. D., Hawks
Park P. O., New Smyrna. 1918

Eighth District—Alachua, Baker, Bradford, Levy and
Putnam Counties: J. H. Hodges, M. D., Gaines-
ville 1916

Ninth District—Calhoun, Holmes, Jackson and Wash-
ington Counties: J. S. McGeachy, M. D., Chipley, 1918

Tenth District—DeSoto, Lee, Manatee and Polk Coun-
ties: Y. E. Wright, M. D., Wauchula. 1916

Eleventh District—Dade, Monroe and Palm Beach
Counties: W. R. Warren, M. D., Key West. 1917

Next Meeting—DeLand—May 12-14, 1915

"MOTHERHOOD WITHOUT FEAR."

"A few months ago *McClure's* magazine announced to the prospective mothers of the country that a remarkable discovery had been made by which the pangs of childbirth were to be forever abolished. The announcement was made in the form of an article by two women, apparently of no medical training. The remarkable discovery was the long-discredited scopolamin-morphin analgesia, first suggested in 1902. This sensational article was taken advantage of by a pharmaceutical firm for free advertising of a nostrum, based on a similar formula; a number of physicians previously unknown brought themselves into newspaper prominence with naive statements regarding their ability in the use of the method and with reports of their success; a host of 'sob-writers' and sisters of the pen, whose work is tested by their ability to wring anguish from sympathetic hearts, filled columns of the daily press and magazines with pseudo-scientific rubbish.

"And now when this sensation has about died out, we are supplied with another," says *The Journal of the American Medical Association*. "This one is furnished by Mr. Vance Thompson, playwright and novelist; the medium is the *Cosmopolitan* magazine.

"As a composition, Mr. Thompson's article is fairly comparable with that of the two ladies who reintroduced 'twilight sleep' to American women; but for sentimental rot, for pseudoscientific rubbish, and for downright sob-writing Mr. Vance Thompson must be given the palm. In one place he says:

"I do not write of this discovery as being in an experimental stage. It has been accepted by the French Academy of Medicine—the date was the third week in July. Surgeons, gynecologists, chemists, doctors of all degrees have examined, tested, approved. For once scientific men have been unanimous."

"There is no excuse for such false statements; even Mr. Thompson could easily have learned the truth.

"What are the facts? What is this 'detoxicated morphin' which, we are told, eliminates the pains of childbirth? Last July, a Ribemont-Dessaignes reported to the Academy of Medicine of Paris a number of cases of childbirth in which he had used, for the relief of pain, a preparation discovered by a chemist named Paulin. The nature of the preparation was not disclosed to the academy. September 1, presumably as a result of the suggestion of Paulin, a request came to the academy from the Minister of War asking the opinion of the academy as to the advisability of using this remedy, presented under the name 'Tocanalginé' and 'Antalgine,' in military hospitals as a substitute for morphin. By unanimous vote the academy declared that, the formula and composition of these medicines being unknown, it could give no opinion. Since it was stated, however, that the new drug was produced by the action of enzymes on morphin, the academy appointed a committee to investigate oxydimorphin, a chemical substance which it was known could be produced by the action of enzymes on morphin. Under the direction of the committee, two chemists examined samples of the new preparation obtained directly from the discoverer. The examination showed that these samples were variable, that they did not contain oxydimorphin, and the only active ingredient found by these chemists was morphin hydrochlorid, and this in quantities varying from 0.05 to 4 per cent. The conclusions of these two chemists were later emphasized by Bertrand who, after careful chemical and biologic tests of samples submitted to him, found that the solid residue was exclusively formed of hydrochlorid of morphin, and that it was fully as toxic and dangerous as morphin, as might be expected; the symptoms of poisoning were exactly the same as those of morphin hydro-

chlorid, and death occurred after the same interval. A dose of the preparation would give about $\frac{1}{2}$ grain of morphin. In other words, judging from the reports which appeared in the *Journal de pharmacie et de chimie* for November 16, and the *Bulletin de l'Académie de médecine* from July 21 to November 17, this so-called 'detoxicated' morphin is essentially a solution of morphin in ampules. It will kill just as quickly as morphin, it will relieve pain just as quickly as morphin—because it is morphin. Naturally the Academy of Medicine of Paris has not accepted the preparation.

"We presume it is useless to protest against this shameless exploitation of the fears of prospective mothers of the country. But if magazines must have articles on this subject, let them at least confine themselves to the facts. The article in the *Cosmopolitan* is cruel, sensational and a disgrace even to yellow journalism."

CONSULT YOUR MATERIA MEDICA OFTEN.

Some time ago a member of the medical examining board of a great state, after reviewing the examination papers of the candidates for license, observed that he was surprised at the paucity of knowledge displayed in the answers to simple questions of Materia Medica and Therapeutics; that the men who are to be the physicians and surgeons of the masses of the people either had forgotten the teachings they received during their college course; had been insufficiently instructed or had allowed themselves to be influenced by the representations of the great pharmaceutical houses that place so many proprietaries on the market.

There are many useful proprietaries placed before the medical profession each year, but there are also many more worthless, valueless and inert, made palatable by various combinations and the liberal use of alcohol.

It is to the discredit of the medical profession that fifty per cent or more of the prescriptions written and filled today are for proprietaries. We allow the detail representative to dictate our *Materia Medica* and *Therapeutics* and do not consult our books on this great important subject.

Attention is directed to some lines on this subject on another page of this issue of *THE JOURNAL*.

LIFE INSURANCE EXAMINATIONS.

It becomes the duty of every medical man at some time to make an examination of an applicant for life insurance and at this time his qualifications are put to a test.

The applicant for insurance is supposed to be a well man; he has convinced himself of that fact or he would not apply for insurance except to fraudulently deceive the examiner and the company. The examination is of entirely different nature from one made on an individual who has symptoms of a subjective character to impart. The sick come for relief and will aid the examiner in every particular, but the applicant for insurance seeks to place before the examiner the fact that he is sound in body and mind.

The fee for a life insurance examination is usually compensatory and is always collectable, the method of examination is left to the examiner and the company relies on him to give it an honest and faithful examination.

Some physicians acting in the capacity of medical examiner are often neglectful, fail to answer questions explicitly or not at all. This delays issuance of the policy and requires extra correspondence.

Our admonition, if one is necessary, is to review the examination blank thoroughly, check every question and answer and if there is additional information that has a bearing on the subject, write a letter of detail to the company.

POISONOUS FLY DESTROYERS.

The December issue of the *Journal* of the Michigan State Medical Society calls attention editorially to the danger of using poisonous fly destroyers.

From July 1 to October 15, 1914, 45 cases of poisoning of young children were reported in the press of a few states and it is pointed out that the symptoms of arsenical poisoning and cholera infantum being very similar there are possibly many more cases of the kind. It might be well in view of this danger for physicians to eliminate the possibility of arsenical poisoning before diagnosing a case as cholera infantum. A few years ago there was considerable agitation against the use of phosphorous matches, partly because of some children being poisoned by eating or sucking heads of the matches. There are doubtless many more cases of the poisoning from the poisonous fly destroyers. Phosphorous matches have been abolished, so should be poisonous fly destroyers.

It seems that this danger has already been recognized by the authorities in far away South Africa and the sale has been forbidden, except by licensed chemists of certain arsenical fly destroyers, more particularly the tin boxes which have a wick or wicks through which the poisoned water is drawn. The fact that sugar is added to draw the flies makes these boxes especially dangerous to young children; furthermore all these poisonous fly destroyers are usually placed on the window sill and the poisons are thus within their reach.

Both the blotting paper impregnated with arsenic (which is put in an open saucer with water and sugar), or the tin boxes with wicks to draw the poisoned water to the surface are extensively used and there is probably no poison so commonly and unnecessarily used where it is perforce within the reach of young children as these various arsenical fly destroyers. In country homes where it often takes some hours to

Obituary

WILLIAM PITT LAWRENCE, M. D. **of Tampa**

Dr. William Pitt Lawrence, of Tampa, one of the best known members of the Florida medical profession, died suddenly at his home in Tampa, on December 24th. Doctor Lawrence was born at Nashville, Tenn., March 28th, 1857, residing in the city of his birth until he was twenty-two years of age. He received his literary education at the Montgomery Bell Academy of Nashville. He commenced the study of medicine in 1873, being but sixteen years of age at the time. Two years later he entered the Medical Department of the University of Nashville, and graduated as an honor man with the class of '78. Immediately upon receiving his degree he commenced the practice of medicine at Ashland City, Tenn., remaining there until 1884, when he came to this state, locating in Orlando. He remained there until 1888 when he returned to his native state, settling in Clarkesville. In 1893 he returned to this state and opened offices in Tampa, which has been his home ever since. Doctor Lawrence served with distinction in the Medical Department of the United States Army during the Spanish-American War. Being assigned on the staff of General Shafter and taking part in the Santiago campaign, his duties were strenuous

until he was himself stricken with yellow fever. Upon his convalescence he was invalided to Montauk Point, where he later resumed active duty. Later assignments took him to Knoxville, Tenn., where he had charge of an ambulance corps, to Cuba where he served as Surgeon to the Second Infantry, and to Fort Thomas, Ky. Upon returning to civil life he resumed his practice in Tampa which he continued until his untimely death last month.

Dr. Lawrence was at one time President of the Hillsborough County Medical Society, and was a Past-President of the Florida Medical Association, being elected to the latter office in 1908.

The deceased leaves behind him a widow and six children, his two sons are William P., Jr., and James L. Lawrence. His daughters are Mrs. F. T. Dickman, Mrs. Frank Struss and Misses Jassamine and Fannie Lawrence. All except Mrs. Dickman are residents of Tampa. She is the wife of an army officer stationed at Manila, Philippine Islands. In behalf of the medical profession of the state of Florida, *THE JOURNAL* extends deep sympathy to the family and to those members of the profession who were in close association with him during his life work.

get a physician, and even in our cities among the foreign born, where the parents are as is well known, slow to call the services of a physician for childish ailments, the danger is especially great. There are as effective and more sanitary ways of killing flies. *Poisonous fly destroyers are an unnecessary evil and should be relegated to the past like the phosphorous match.*

COUNTY SOCIETY NEWS.

BREVARD COUNTY.

The following officers were elected for the ensuing year at the December meeting of the Brevard County Medical Society:

W. L. Hughlett, President.
L. H. Martin, Vice-President.
J. C. Spell, Secretary-Treasurer.

DADE COUNTY.

At the December meeting of the Dade County Medical Association, the following officers were elected for the ensuing year:

Howard Switzer, President.
Mary Freeman, Vice-President.
E. Frederick Sayles, Secretary-Treasurer.
W. S. Gramling, Member of Board of Censors.

J. M. Jackson, Delegate to the State Association meeting, and J. G. DuPuis, alternate.

ESCAMBIA COUNTY.

Dr. J. H. Fellows, of Pensacola, is receiving the congratulations of his many friends upon his marriage to Mrs. Charles Dillingham, of Atlanta, which took place on December 22nd, at Pensacola. Dr. and Mrs. Fellows are spending their honeymoon in Havana and other points of interest in Cuba. They will return shortly and will be at home to their friends after February first.

Dr. Fellows is one of the leaders of the profession in the western part of the state and his many friends extend to him and his

bride their sincere wishes for a happy and prosperous career.

The many friends of Dr. J. J. Durrett, who at one time was a resident of Pensacola, but now living in Tuscaloosa, will be interested in the following taken from the *Tuscaloosa Times-Gazette*:

"Dr. J. J. Durrett was elected county health officer at a meeting of the Tuscaloosa County Medical Society which was held in the Rosenfeld building Monday night. His duties will be to look after the public health of the county and city, taking the places of the county health officers, Dr. D. W. Ward, county health officer; Dr. Alston Maxwell, city health officer, Dr. Geo. H. Searcy, city school inspector, and Dr. W. M. Faulk, physician for the jail and the county alms house. Dr. Durrett will devote his full time to the work that was formerly done by the above named physicians and will not engage in private practice at all.

"The selection of a county health officer to devote his full time looking after the public health of the county and city is a new movement and met with the hearty approval of all the physicians, including those who gave up their positions in order to make it possible to employ one physician for his entire time. The work of Dr. D. W. Ward as county health officer, Dr. Alston Maxwell as city health officer, Dr. G. H. Searcy as city school inspector and Dr. W. M. Faulk as physician for the jail and alms house has been such as to rank Tuscaloosa city and county among the healthiest in the state, and they are to be commended for their patriotic work and spirit in hearty favoring this progressive movement for Tuscaloosa county."

BOARD OF MEDICAL EXAMINERS' MEETING.

The last meeting of the Regular Board of Medical Examiners was held at Palatka on December 2nd and 3rd, 1914. During the intervening six months since the pre-

ceding examination 22 temporary licenses had been issued to doctors locating in the state. 55 applicants were present for examination, of whom 36 were successful and 19 failed. 3 were issued licenses who had failed but whose credits for years of practice brought them up to the required general average of 75%.

The various medical colleges were represented at the examination as follows, viz.: Atlanta School of Medicine, 4; Atlanta College of Physicians and Surgeons, 3; Meharry Medical School, 3; Tulane University, 2; University of Tennessee, 2; Rush Medical School, 2; University of Maryland, 2; Medical College of Virginia, 2; Boston College of Physicians and Surgeons, 2; University of Georgia, 2; University College of Medicine of Virginia, 2; Kentucky School of Medicine, 2; Memphis Hospital College of Medicine, 2; Atlanta Medical College, 2; Chicago College of Medicine and Surgery, 2; Ohio Medical College, 1; Kansas Medical College, 1; University of the South, 1; Vanderbilt University, 1; South Carolina Medical College, 1; University of Paris, 1; Harvard University, 1; Johns-Hopkins University, 1; Northwestern University Medical School, 1; Baltimore College of Physicians and Surgeons, 1; Yale Medical School, 1; Southern College of Medicine and Surgery, 1; Central College of Physicians and Surgeons, 1; Marquette University School of Medicine, 1; College of Physicians and Surgeons of Columbia University, 1; Bennett Medical School, 1; Lincoln Memorial University Medical Department, 1; Purdue University, 1; Maine Medical College, 1; Leonard School of Medicine, 1; University of Colorado Medical School, 1; Missouri Medical College, 1; Woman's Medical College of Pennsylvania, 1.

The various states were represented as follows, viz.: Florida, 9; Alabama, 5; Illinois, 4; North Carolina, 4; South Carolina,

3; Indiana, 3; Georgia, 3; Ohio, 2; Mississippi, 2; Cuba, 2; Tennessee, 2; West Virginia, 2; Texas, 2; New York, 1; Kansas, 1; Porto Rico, 1; Jamaica, W. I., 1; Massachusetts, 1; Wisconsin, 1; New Jersey, 1; Nebraska, 1; Kentucky, 1; Maine, 1; British Guiana, S. A., 1; Louisiana, 1; Vermont, 1; Greece, 1.

That Florida is attracting considerable attention from the medical profession of the country as well as from other lines, is evidenced by the fact that during the past year slightly above 700 requests for information about the requirements for practicing medicine legally in the state were received and a large percentage of them asked for reciprocity privileges but which under our present law the Board was unable to grant. Those requests came mainly from New England, the Middle and Northwestern states. 152 applicants have been examined during the year and 99 licenses have been issued. 2 licenses were issued under the provision of the law exempting from examination those who practiced in the state prior to 1889, when our first medical law went into effect.

RHINITIS—ACUTE AND CHRONIC.—While simple acute rhinitis is, in the large majority of cases, an innocent offender, its neglect by the patient often results in secondary infections of the accessory sinuses and the ear complications. It is such a common-place affection that patients usually ignore it until brought face to face with its possibilities. It is safe to say that if all cases of acute rhinitis were given proper treatment in the early stages there would result a marked decline in the demand for surgery of the accessory sinuses, middle ear and mastoid. There would also be much less of the chronic rhinitis which frequently has its origin in neglected cases of the acute form. In other words control the early rhinitis and the patient escapes most of the painful and persistent sequelae which are so common in neglected cases. Preventive medicine constitutes the highest degree of efficiency in our profession and as rhinologists we have a large responsibility in educating our patients and the general practitioners in the matter of safeguarding themselves against the ravages of this supposedly commonplace disease.—Louis J. Goux, M. D., in *The Journal of the Michigan State Medical Society*.

MATERIA MEDICA.

Open your Materia Medica—read a page
or two,
'Twill benefit your patient—it may be good
for you.

Much you read is useless, more is good by
far;
Consider the ingredients, take the best at
par.

It may be only a compend, reviewed for
hasty exam,
Your mind with facts you'll fortify, and
theory be damn.

Study physiological action, apply thera-
peutic test,
Rely on known authority, expect results
with zest.

Physiologic actions vary, therapeutics cause
suspense.
Idiosyncrasies considered appeal to com-
mon sense.

Don't blame the drugs if the patient seems
to not improve,
Consider your diagnosis—an error you may
remove.

Open your Materia Medica, covered with
dust and brown,
Peruse its pages early and after the sun
goes down.

Its pages will give you comfort, its pages
will give you rest,
When the patient is quietly sleeping from a
therapeutic test.

The detail man is ready with a vaunted
panacea;
Take your Materia Medica, each statement
test in clear.

Let each and every ingredient stand the test
of science,
Read your Materia Medica, for that's the
best reliance.

Many a doctor has foundered on the reefs
of proprietaries,
Swallowing "hook and sinker" of the detail
illuminiaries.

He praises the combination, 'tis full of po-
tent action,
But he fails to elucidate the direful complex
fraction.

Of incompatibles, inert drugs, antagonists
and punk,
Of shot-gun mixtures, sleeping dope and
nothing much but junk.

Its elixir this, elixir that and syrups forty
or more,
Many extracts, cure-all tonics and mixtures
by the score.

The preparations chemically correct per
argument,
Analysis shows lots of drugs and alcohol—
? per cent.

The detail man has a thing to sell, and has
a wage to earn,
He's paid to talk his line of stuff and you
are there to learn.

Treat him kindly, courteously, thank him
for his toil,
Review your Materia Medica and "burn the
midnight oil."

Open your Materia Medica, read its pages
through,
Here's a potent alkaloid and several sera,
too.

Which is the better agent, concoctions of
many kind,
Or a number of active principles, fifty kept
in mind?

Councillors active and faithful, comforters
free from dope,
And never a one of the fifty to lessen your
ardent hope.

Use them with discretion, from all select a
few,
If diagnosis is correct they'll aid and com-
fort you.

Take the word of authority, examine the
contents well,
On the facts of past experience allow your
mind to dwell.

—ANONYMOUS.

Reviews from Current Literature

SKIN GRAFTS.

Davis, John Staige: *The Use of Small Deep Skin Grafts*. J. A. M. A., 1914, Vol. LXIII, p. 985.

Davis contributes another excellent article to the subject of skin-grafting. The writer's well-known studies and experiences along this line lend authority to any statement he may make, and demand for his articles instant attention. He has revived and slightly modified the Reverdin method of skin-grafting and has perfected the technic. He states that the ultimate results are better with this than with any other method.

In 1869 Reverdin first used small detached bits of skin to hasten the healing of granulating wounds. The procedure was in vogue until gradually supplanted by the use of larger grafts, as advocated by Ollier in 1872 and Thiersch in 1886. Since then the Reverdin graft has been used but seldom, though the final results are fully as good as in the newer operations.

The grafts may be placed on fresh wounds, but the best results are obtained where they are applied to a clean, firm, pink granulating surface.

In preparation, the granulating surface should be cleared of all crusts and secretions the day before operation, painted with tincture of iodine and dressed with, preferably, Balsam of Peru 1 part, castor oil 3 parts. This dressing is removed in the operating room, the wound washed with salt solution without causing bleeding and the surface dried thoroughly by pressing dry gauze firmly on the granulations.

Davis states that an absolutely dry surface is a decided factor in the success of the procedure.

No pre-operative preparation is needed for the area from which the grafts are to be taken; shaving, washing with green soap and water, rinsing with ether, then alcohol, and finally with normal salt solution and drying constitutes the operating room preparation.

The area may be anaesthetized locally with quinin and urea solution or novocain, 0.5 per cent solution, without affecting the grafts.

The tiny grafts should be cut by elevating a bit of skin with a sharp needle, and cutting through the base of the cone thus formed with a sharp scalpel. Cutting the grafts with forceps and scissors traumatizes the tissue and endangers the life of the graft.

The raw surfaces of the grafts are placed against the granulating surface and pressed out with dry gauze. They should be placed closely; the best results being obtained when a space of not more than 5 m.m. is left between grafts.

The grafted area is covered by dry sterile rubber protective, applied in strips and pressed down smoothly and firmly as each row of grafts is placed. Moist salt gauze may be secured by bandage over the strips of protective.

The area from which the grafts are taken should be dressed with boric acid ointment covered by rubber protective.

The grafts are dressed on the second or third day, and any secretions mopped up, or carefully irrigated with salt solution; as soon as new epithelium is shown about the grafts a bland ointment may be applied, and when all spaces are filled the grafted area should be dusted with zinc stearate and dried by exposure to the air.

If epithelial proliferation is sluggish, the writer suggests the occasional application of 8 per cent scarlet red in zinc ointment.

The grafted area should be immobilized and protected from injury until sound. Gentle massage is advised after three weeks.

Davis states that the age of the patient has apparently little effect on the healing of the grafts, that contraction is not likely to occur if the grafts are placed closely together, and that they are not replaced by

scar tissue, but persist as islands of normal skin.

A wound healed by small grafts has a dotted appearance, therefore when a cosmetic result rather than sure and rapid healing is the prime desideratum, Thiersch grafts should be used.

R. C. T.

FRACTURE AND FRACTURE DISLOCATION OF THE SPINE.

Palmer, E. Payne: *Bone Transplantation as a Treatment of Fracture and Fracture-Dislocation of the Spine.* Surg., Gynec. and Obst., 1914, Vol. XIX, p 664.

The writer calls attention to the gravity of spinal injuries and to the fact that a majority of such cases, if they do not terminate fatally, end in total paralysis below the injured segment of the cord.

He states that while it is true that in many cases of fracture-dislocation of the spine the cord is wholly or partially severed and will never regenerate, yet late operation shows in other instances, that the only lesion to the cord is compression by bone or clot within or without the dura, which pressure, if it had been relieved within a few days after injury, would not have produced true degeneration.

Results in late operation have been most unsatisfactory, because of degeneration of the cord, and for this reason, operations on the spine for injury are in more or less disrepute.

Palmer states that there is always uncertainty regarding pathological conditions; determination of the actual damage to the bony canal is not a guide to the damage done to the cord; pressure paralysis may be the result of a blood clot as well as bone distortion, hence the only safe course is to do an exploratory laminectomy in all cases of spinal injury presenting paralysis and deformity, within the first few days after injury, to determine definitely whether operative treatment will improve conditions. The operative technique, as in all work upon the brain or cord, must be faultless.

The writer's reported case is a splendid example of the excellent results to be obtained by prompt and efficient work; his patient sustained a fracture of the twelfth dorsal and first lumbar vertebrae; deformity was apparent; the spinous process of the twelfth dorsal was depressed and freely movable; pain was intense; there was partial loss of sensation and motion in the lower extremities. Immediate operation was done. It was found that both laminae of the twelfth dorsal and the right lamina of the first lumbar were fractured and that the cord was compressed by angulation of the spine. Laminectomy on the first lumbar relieved the pressure and the patient made an uneventful recovery without motor, sensory, bladder or bowel disturbances.

Three weeks after the primary operation, to strengthen the weak spine, and to do away with prolonged immobilization in casts, or braces, a strong bone transplant was taken, after the method of Albee, from the tibia and imbedded in the split spinous processes of two vertebrae above and two below the injured area.

The patient was kept on her back for seven weeks, after which movements were instituted. She left the hospital twelve weeks after injury, able to walk with assistance, and eventually walked without help and with nearly a normal gait.

The writer in his summary suggests that:

1. All cases of spinal injury with paralysis and deformity should have an immediate exploratory laminectomy.

2. Bone transplantation offers hope to many unfortunates who are dependent on braces or casts.

3. When done as a secondary operation it is not necessary to enter the cord zone. A strong bony transplant gives immediate immobilization, extension, and support to the injured spine, which can be secured in no other way.

R. C. T.

EMPHYEMA.

Dunlop, H. G. M.: Empyema in Children. *Edinburgh Med. Jour.*, 1914, Vol. XIII, p. 4. Abs. by *Surg., Gynec. and Obst.*, Nov., 1914.

Dunlop reports his observations from a study of 98 cases of empyema in the Sick Children's Hospital.

Pleural effusion occurred once in every nine cases of pneumonia, and in children under three years of age, 53 of 59 cases were purulent. He emphasizes the fact that the younger the child the greater the likelihood of purulency; after the age of ten purely serous effusion is the rule.

Analysis of the purulent fluid revealed pneumococcus alone in 53 cases, streptococcus alone in 16, pneumococcus and streptococcus in 14; staphylococcus alone in 3; tubercle bacilli were found alone in 3 cases, while no growth was obtained in 6; 69 per cent of the cases were secondary to lobar pneumonia.

"The onset may be acute, often with a convulsion occurring during the course of the primary disease, or it may be very insidious. Many cases enter the hospital under the diagnosis of atrophy, miliary tuberculosis, or congenital syphilis. In the symptomatology stress is laid on the very sick, pinched, and anaemic* appearance of the child, which changes to an earthy color as the rapid emaciation characteristic of the condition ensues. There is usually some cough and dyspnoea, though the latter may be very slight even in the presence of massive effusion. In most cases there is a rise in temperature of four or five degrees, but in very weak and emaciated infants it may be absent. There is generally leukocytosis of 20,000 to 30,000. The skin is usually dry and harsh and after a time the fingers tend to have a club-shaped appearance.

"The observation of others as to the presence in many cases of tubular breathing over large effusions in children is confirmed. The displacement of the heart and the presence of a tympanitic area over a resistant flatness extending to the base of the lung are held

very valuable diagnostic signs. Purulent pericarditis was by far the most common complication and is to be suspected when improvement fails to take place following drainage. In differentiation from serous pleurisy and other pathological conditions of the chest the needle should be unhesitatingly employed."

The author advocates evacuation of the pus as soon as the diagnosis is established, either by preliminary aspiration, followed by incision through the sixth midaxillary interspace, or by rib resection if the more radical procedure is indicated.

R. C. T.

DECORTICATION OF THE LUNG.

Fowler, Russell S.: Decortication of the Lung. *Surg., Gynec. and Obst.*, 1914, Vol. XIX, p. 667.

Fowler reports a successful case of complete removal of the parietal and visceral pleura for empyema in a child two years of age. The pleura was incised and drained six months previously, but in spite of all efforts the lung failed to expand.

The Fowler-Delorme operations aim to return the contracted and collapsed lung to its normal condition by removing the infected pleura which binds it down, rather than to obliterate the infected pleural cavity and permanently collapse the lung by sinking in the chest wall as in the Schede procedure.

The soft tissues are elevated from the bony chest wall by a large L-shaped flap. The ribs are removed sub-periosteally, beginning with a resection of about six inches below and gradually decreasing as the apex of the chest is reached. The cavity is then opened widely by a straight longitudinal incision, ligating each intercostal artery as it is cut. The entire parietal and visceral pleura is then detached, in one sheet or in strips, with as little injury to the lung as possible.

Fowler states that in the case reported the lung could be seen expanding and beginning to fill the cavity as the work progressed. Eventually the ribs regenerat-

ed along the periosteum which was left in place; the wounds healed, and the lung expanded and filled the chest cavity.

R. C. T.

ERYSIPELAS.

Polák, Otto: The Treatment of Erysipelas with Antidiphtheria Serum. *M. m. W.*, Nov. 24, 1914.

A very desperate case of erysipelas in an infant of 3 months was brought to the hospital. All expected it to die. It was given an injection of antidiphtheria serum. Next morning, to the surprise of all, the infant was much better. The injection was repeated, and in 24 hours the infant was apparently well.

In 15 subsequent cases the results were just as promptly manifested. These successes were followed by 4 failures, the last of which was promptly rescued by a larger injection. 1,500 units were used for each injection in the author's first cases. Subsequently 3-4000 units were used and results have been more satisfactory.

In uncomplicated cases the temperature ends by crisis in from 24-36-48 hours, the redness and swelling disappear, and an astonishing euphoria is manifest. This sense of well-being is often felt even before the temperature has had time to drop. Injections are repeated if after 24 hours the temperature has not begun to drop.

Cases in which the erysipelas is a complication respond to the serum injection only to the extent to which the symptoms are caused by the complication of erysipelas.

In response to a letter of inquiry the author received notes on 105 cases of erysipelas treated with antidiphtheria serum. Typical results were obtained in 82 per cent. Adding his own cases a splendid result was obtained in 85 per cent. In closing the author emphasizes once more that these splendid results are obtained only in pure cases of erysipelas, *i. e.*, cases in which the erysipelas is not a complication. When it is a complication the serum will exert its influence on it only, not on the original trouble,

therefore results will not be so satisfactory.

T. T.

TWILIGHT SLEEP.

Knipe, Wm. H. Wellington: The Freiburg Method of Dämmerschlaf or Twilight Sleep. *American Jour. Obstet.*, December, 1914, Vol. LXX, p. 884.

Dämmerschlaf is the name given to that condition of mind in which the patient remains perfectly conscious and intelligent but at the same time loses a knowledge of present events when they are completed. It is induced by the use of scopolamin and morphine, or one of its derivatives, in suitable doses. In 1903 Steinbuchel, of Gratz, reported the first series of cases in which it was used to alleviate the pains of childbirth. His experience with the method was favorable and he found no untoward results.

During the next few years others tried the method with varying results. Gauss, of Freiburg, took up Steinbuchel's method and in 1906 reported his first 300 cases. He made some changes in Steinbuchel's technique and obtained more satisfactory results. His second report of 1,000 cases, published in 1907, showed a still greater improvement in his statistics.

Numerous other observers published their experience with the Dämmerschlaf. The majority of them were favorable. Among those who condemn the method are Hoch-eisen, Steffen and Gminder. Gauss claims that their bad results were due to poor technique, either by using decomposed solutions of scopolamin, incorrect dosage or administration.

The Dämmerschlaf, according to Gauss, is divided into three zones: First, that in which impressions are stored in the memory although there may be a diminution of pain felt. Second, that in which impressions are neither perceived at all nor stored in the memory, the patient being in a stage of complete narcosis. Third, a zone between these two in which perception is present but events are not stored up in the memory. This is the stage which should be reached but not

passed. Unfavorable results are obtained when either too small or too great a dosage is employed.

On account of the varying susceptibility of different people to scopolamin the question of the actual dosage in a given case is difficult to determine. The successful basis of twilight sleep is the proper use of "memory tests." Some object is shown to the patient and after an interval of from twenty to forty minutes the same object is again shown and the patient asked if she has ever seen it before. A negative answer indicates that at the time it was first shown the patient was in the twilight sleep.

The first dose given usually is 0.01 gm. of morphine muriate, followed at once by 0.0003 gm. to 0.00045 gm. scopolamin solution. Forty-five minutes later the memory test is started. One hour and fifteen minutes after the injection the memory test is completed. If negative the second injection is given, 0.00015 gm. to 0.0003 gm. to 0.00045 gm. scopolamin, but no morphine. If necessary a third injection, 0.00015 gm. scopolamin, is given. The essential point in the proper induction of the condition is a gradual, subtle scopolamin technique, beginning with small doses and reaching the twilight zone gradually. Failures are due to errors in this technique.

The above method is the perfected method of Gauss. Most visitors to the Freiburg clinic during the last year have seen a different method demonstrated, that of Seigel. This method endeavors by a routine dosage, practically the same in all individuals, to attain the same results. It is fairly successful as far as the mother is concerned but more dangerous to the child and can not be recommended, therefore, as a routine for general use.

Gauss also insists on the proper preparation of the scopolamin. In watery solutions it quickly decomposes after sterilization and toxic by-products are formed. To prevent this ten per cent of the sexatonic alcohol mannit is added to the solution.

At Freiburg and elsewhere there have been over 8,000 cases of twilight sleep with very excellent results both for mother and child. All bad results reported have been due, according to Gauss, to faulty preparations of the drug or to errors in method.

Skill, careful attention and the knowledge derived from experience are necessary to properly conduct twilight sleep. It also requires greater obstetrical knowledge than the ordinary obstetrical case demands. It is therefore essentially a hospital proposition and the ability to properly use the method can only be acquired after careful study, experience and observation.

The post-partum treatment of the patient at Freiburg differs from that in general use. The patient sits up in bed in the second twenty-four hours and is out of bed in a chair on the third day. Passive exercises of the extremities, abdomen and back are also used. The normal case usually leaves the hospital on the sixth or seventh day. It is claimed that, in place of bad results following this unusual treatment, the involution of the uterus is hastened by it, and that the patient does better in other ways.

Since studying the method of Gauss, Knipe has used it in eighty-one hospital cases with satisfactory results, the detailed statistics of which are given in his paper. He gives his opinion of the Gauss method as follows: "So that we feel that the enthusiasm of Gauss is based upon experience with his skillful technique; if our good results continue it will be difficult for us not to grow enthusiastic also."

G. R. H.

CASEIN-CALCIUM MILK.

Rost, Wm. L.: Observations on the Use of Stoeltzner's Casein-Calcium Milk in the Treatment of Summer Diarrhoeas of Infancy and Early Childhood. Archives of Pediatrics, Nov., 1914, Vol. XXXI, p. 849.

Stress is placed on the desirability of feeding children, suffering from diarrhoeal disorders, on something of a high food value and likewise undisturbing to digestion. The prolonged feeding with food of such

little value as rice and barley water too often results in serious loss of weight and a reduction in food tolerance.

To a large extent all the requirements of an ideal food are met with in the protein milk of Finkelstein & Meyer. To this food there are certain objections, most notably its cost and difficulty of production; and to overcome these objections the employment of casein-calcium milk is advocated.

Casein-calcium as artificially prepared is a white, fine granular powder and when added to properly diluted boiled milk produces a food with practically the same composition as protein milk. The author reports fifty-six cases of infantile diarrhoea treated with casein-calcium milk with strikingly favorable results. He finds that it can be employed alone or in combination with breast milk and that its use can be continued for some weeks to good advantage.

J. D. L.

INFLUENZA.

Holt, L. Emmett: Some Manifestations of Influenza in Young Children. *Archives of Pediatrics*, Oct., 1914, Vol. XXXI, p. 724.

The author believes that influenza alone and as a complication of other diseases exists oftener than is generally believed. He deplores the custom of using the term "influenza" as a cloak for our ignorance of the causation of many obscure conditions, but on the other hand is positive that Pfeiffer's bacillus is alone responsible for the very definite disease known as influenza. It is most prevalent during the latter part of winter or early spring and disappears with the advent of warm weather.

The B. influenzae is more responsible for conditions of the lower respiratory tract, such as the trachea, bronchi and lungs, than of the upper respiratory tract—the nasopharynx and ears. To apply the term influenza to severe head colds is a misnomer. The author remarks on the peculiar range of temperature which accompanies influenza. It is high, fluctuates widely without appar-

ent cause, its rise is without chills and its fall is rapid and frequently goes to subnormal.

There is a lack of correspondence between general symptoms and the temperature which is quite diagnostic, and finally there is probably no disease in which high temperatures exist with so few general symptoms as influenza.

There is pointed out the marked similarity that exists between whooping-cough and certain cases of influenza accompanied by paroxysmal cough. Most children reported to have recurrent attacks of whooping-cough in reality suffer from influenza. Many other respiratory disorders, especially pneumonia, are accompanied by influenza and the period of illness is thereby prolonged. All respiratory infections complicated by influenza or solely due to the B. influenzae are seldom benefited by cold air, though fresh air is certainly needed (a point of practical significance bearing on the treatment of uncomplicated pneumonia and influenza-pneumonia).

J. D. L.

BOILED MILK IN INFANT FEEDING.

Dennett, Roger H.: The Use of Boiled Milk in Infant Feeding. *Journal A. M. A.*, Dec. 3, 1914, Vol. LXIII, p. 1991.

The relative value of boiled and unboiled cows' milk is discussed with reference to its bearing on several subheads. The questions raised are whether or not the prolonged use of boiled milk may cause such nutritional disorders as rickets, anæmia, malnutrition and scurvy; whether or not a change may be abruptly made from raw to boiled milk without causing digestive disorders; whether or not the employment of boiled milk may assist in overcoming disturbances of intestinal digestion; whether or not boiled milk causes constipation; whether or not the nutritional value of milk is lessened by boiling. After citing his own experience with both boiled and raw milk and reporting a number of feeding cases occurring in his own practice the

author demonstrates a decided leaning to the use of the boiled product. He finds that frequently nutritional disturbances occurring in children fed on raw milk are overcome on boiling the food. That the prolonged use of boiled milk is consistent with perfect nutrition; that it does not cause such disorder as poor musculature and malnutrition; that the administration of orange-juice will prevent scurvy in children fed on boiled milk; that boiled milk is not more difficult to digest than raw milk; that boiled milk is probably more apt to cause constipation than raw milk; that the evidence is not conclusive whether the food value of milk is lessened by boiling or not.

J. D. L.

AUTOGENOUS SERUM IN THE TREATMENT OF PSORIASIS.

Fox, Howard: Autogenous Serum in the Treatment of Psoriasis. *Journal of A. M. A.*, Vol. LXIII, p. 2190.

Fox in a very interesting article gives his clinical results from the treatment of twenty-eight psoriasis cases with autogenous serum, the patients being of different sexes, and ages; the various forms of the disease were present, from the simple guttate to the more diffuse type; the duration of eruption in the different cases was from two to forty-five years. All of the patients were treated in the ambulatory way, with the exception of two who remained in the hospital for two weeks. Three injections of serum were given in most cases, at intervals of three to five days, these injections were followed by the local use of a ten per cent chrysarobin ointment, no internal medication was given nor was any particular diet instituted. Fox considers the results from treatment in general very satisfactory, and in some of the cases decidedly brilliant. The article is illustrated with eight photographic cuts showing the cases before and after treatment. The writer concludes that:

1. Autogenous serum, when used alone, does not appear to be of value in the treatment of psoriasis.

2. It is of decided value in many cases when used in conjunction with chrysarobin. Obstinate cases of psoriasis that have long resisted vigorous treatment with chrysarobin ointment will often yield to this remedy when injections of autogenous serum are given.

3. Intravenous injections of autogenous serum, if properly given, are entirely devoid of danger.

4. The technique of preparing the serum and giving the injections is comparatively simple.

J. L. K-S.

SALVARSAN AND NEOSALVARSAN.

Heidingsfeld, M. L.: "Salvarsan and Neosalvarsan Treatment of Syphilis. A Study of 4,550 Serological Examinations," *Ohio State Medical Journal*, 1914, Vol. 10, p. 653.

Heidingsfeld gives the result of his clinical studies of 176 syphilitics treated in the past four years with Neosalvarsan and Salvarsan, serological examinations were made to the number of 4552 in these cases, Salvarsan was given 625 and Neosalvarsan 589, the administrations were all intravenous and the doses more or less uniform 0.6. The Wasserman examinations were made prior to every initial injection, and when practical every thirty days thereafter until the blood became negative and remained negative constantly for sixty to ninety days. In this series of cases 193 could not be systematically followed, of the remainder 524 cases which were treated with Salvarsan or Neosalvarsan 75 per cent progressed to a clinical and laboratory recovery. Heidingsfeld's experience in this series of syphilitic cases treated solely with Salvarsan and Neosalvarsan is that in some cases a patient under Salvarsan treatment with a positive serological report will report negative when given Neosalvarsan and the same for Neosalvarsan, while repeated injections of either drugs may cause the spirochæte to develop a tolerance for the drug, the same as has been mentioned in the past in the treatment of syphilis with mercury. The

writer shows the importance of serological examinations in the rational treatment of syphilis.

Heidingsfeld is strongly impressed from his clinical experience, that Salvarsan and Neosalvarsan are both effective agents for the successful treatment of syphilis possessing differential therapeutic properties. His clinical experience leads him to believe that the spirochæte promptly acquire an immunity for each of these preparations. He would place each of them in the front rank of the thus far recognized successful anti-syphilitic remedies. Their therapeutic value as measured by clinical and laboratory results, greatly overshadows mercury, iodides, and any of the arsenical preparations which so far have been used with a fair degree of success in the treatment of syphilis. Heidingsfeld believes that these two more powerful and successful remedies (Salvarsan and Neosalvarsan) should take precedence and, if possible, supersede the other less effective and more unsatisfactory ones. He believes that the spirochaete promptly acquires an immunity for any therapeutic agent which has thus far been employed in the treatment of syphilis and which in and of itself precludes successful treatment in the obstinate and refractory cases. The writer claims that this baleful condition or influence can be circumvented by alternating Salvarsan and Neosalvarsan, giving the latter in the first six months of treatment, and then after an interval of a few months if necessary give Salvarsan, alternating this until the necessary negative Wasserman is obtained.

The importance of frequent and systematic Wasserman examinations is very strongly urged in Heidingsfeld's interesting article, the procedure being essential to an intelligent treatment of syphilis.

J. L. K-S.

BLOOD PLATELETS.

G. B. Webb, M. D., G. B. Gilbert, M. D., and Leon C. Havens, M. A.: *Blood Platelets and Tuberculosis*, Archives of Internal Medicine, 1914, Vol. XIV, p. 743.

In giving their results of the study of blood platelets and tuberculosis, Webb, Gilbert and Havens first quote Adami and Nichols for a description of the platelets and give two micromillimeters as the average diameter of the platelet. They are non-nucleated granular structures which are mostly neutrophilic but also contain other granules which have a tendency to show chromatin stains.

The platelets vary from two hundred thousand to seven hundred thousand per cubic millimeter. In regard to origin they speak of the work of J. H. Wright, of Boston, who has demonstrated that some at least are shown to be buddings and offshoots from giant cells of the bone marrow, megakaryocytes. The normal number of platelets is from two hundred and thirty thousand to two hundred and forty thousand. They are decreased in acute infectious diseases and show a tendency to increase in chronic diseases. They have also found that platelets in certain animals contain antibodies for anthrax bacilli. The platelets were found to be increased in tuberculosis as will be shown a little later. Their composition is thought to be largely nucleoproteid.

Reference is made to Welch's work showing platelets to be the first element in the formation of the thrombus.

Webb, Gilbert and Havens made a series of counts at sea level and another series at an altitude of six thousand feet. The comparison of averages from the two counts shows an increase of 12.2 per cent for counts made at six thousand feet. The counts were made at New York and Colorado Springs.

The counts in tuberculous cases were shown as follows: afebrile cases, three hundred and sixty-eight thousand; advanced quiescent cases, four hundred and twelve thousand; advanced active cases, four hundred and ninety-six thousand. In children with measles they found the count low in the early stages but increased during convalescence.

A series of experiments were undertaken where emulsions of platelets were added to suspensions of tubercle bacilli before inoculating guinea pigs. Cultures of varying virulence and in varying amounts were mixed with blood platelet emulsions and inoculated in guinea pigs without showing absolute definite results. They believe, however, that where these platelet emulsions are mixed with the tubercle bacilli that the disease is modified and that the infection is delayed in the experimental animal.

H. H.

NEW AND NONOFFICIAL REMEDIES

E. R. Squibb and Sons:

Acne Vaccine, boxes of 4 syringes containing 25, 50, 100 and 200 million killed bacilli, boxes of 2 syringes containing 50 and 200 million killed bacilli, boxes of 6 ampoules containing 10, 25, 50, 100, 200 and 500 million killed bacilli, with syringes, and boxes of 3 ampoules containing 50 and 200 million killed bacilli with a syringe; Bacillus Coli Communis Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli. Also boxes of 2 syringes containing 100 and 500 million killed bacilli and boxes of 2 ampoules containing 100 and 500 million killed bacilli, with a syringe. Box of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed bacilli, with a syringe; Bacillus Pertussis Vaccine, boxes of 4 syringes containing 25, 50, 100 and 200 million killed bacilli. Also boxes of 2 syringes, containing 50 and 200 million killed bacilli, boxes of 6 ampoules

containing 25, 50, 100, 200, 300 and 500 million killed bacilli, with a syringe, and boxes of 2 ampoules containing 50 and 200 million killed bacilli, with a syringe; Diphtheria Antitoxin, syringes containing 2,000, 3,000, 4,000, 5,000, 7,500 and 10,000 units; Gonococcus Vaccine, 4 syringes containing 100, 200, 350 and 500 million killed gonococci, boxes of 2 syringes containing 100 and 500 million killed gonococci, boxes of 6 ampoules containing 50, 100, 150, 350, 500 and 1,000 million killed gonococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed gonococci, with a syringe; Meningococcus Vaccine, Curative, boxes of 4 syringes containing 100, 200, 400 and 500 million killed meningococcus; also boxes of 2 syringes containing 100 and 500 million killed meningococci, boxes of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed meningococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed meningococci, with a syringe; Meningococcus Vaccine, Immunizing, boxes of 3 syringes containing 100, 500 and 1,000 million killed meningococci; Pneumococcus Vaccine, boxes of 4 syringes containing respectively 100, 200, 400 and 500 million killed pneumococci, boxes of 2 syringes containing respectively 100 and 500 million killed pneumococci, boxes of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed pneumococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed pneumococci, with a syringe; Pyocyaneus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli; also in boxes of 2 syringes containing 100 and 500 million killed bacilli, box of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed bacilli, with a syringe; Smallpox (Varilolaz) Vaccine (Glycerinated), each dose in separate aseptic sealed glass tube, with bulb and needles; boxes

of 5 and 10 tubes; Staphylo-Acne Vaccine, boxes of 4 syringes containing 100 million killed staphylococci and 25 million killed acne bacilli, 200 million killed staphylococci and 50 million killed acne bacilli, 400 million killed staphylococci and 100 million killed acne bacilli, and 500 million killed staphylococci and 200 million killed acne bacilli; boxes of 2 syringes containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million killed staphylococci and 200 million killed acne bacilli, boxes of 2 ampoules containing 100 million killed staphylococci and 50 million killed acne bacilli and 500 million killed staphylococci and 200 million killed acne bacilli, with a syringe, box of 6 ampoules containing 100 million killed staphylococci and 20 million killed acne bacilli, 100 million killed staphylococci and 20 million killed acne bacilli, 500 million killed staphylococci and 50 million killed acne bacilli, 500 million killed staphylococci and 50 million killed acne bacilli, 1,000 million killed staphylococci and 100 million killed acne bacilli and 1,000 million killed staphylococci and 100 million killed acne bacilli, with a syringe; Staphylococcus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed staphylococci, also boxes of 2 syringes containing 100 and 500 million killed staphylococci, boxes containing 6 ampoules containing 100, 250, 500, 500, 1,000 and 2,000 million killed staphylococci, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed staphylococci with a syringe; Streptococcus Vaccine, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed streptococci, also boxes of 2 syringes containing 100 and 500 million killed streptococci, boxes of 2 ampoules, containing 100 and 500 million killed streptococci, with a syringe, boxes of 6 ampoules containing 100, 100, 500, 500, 1,000, 1,000 million killed strep-

tococci, with a syringe; Typhoid Vaccine, Curative, boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli, also boxes of 2 syringes containing 100 and 500 million killed bacilli, boxes of 6 ampoules containing 200, 200, 500, 500, 1,000 and 1,000 million killed bacilli, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed bacilli, with a syringe; Typhoid Vaccine, Immunizing, boxes of 3 syringes containing 500, 1,000 and 1,000 million killed bacilli.

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ACNE VACCINE.—Marketed in packages of four syringes containing, respectively, 5, 10, 20, and 40 million killed acne bacilli. Schieffelin and Co., New York.

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COLON VACCINE.—Marketed in packages of six syringes each containing 1,000 million bacteria. Greeley Laboratories, Inc., Boston.

COLON VACCINE.—Marketed in packages of two vials each containing, respectively, 50, 100, 200 and 400 million killed bacteria. Schieffelin and Co., New York.

DIPHTHERIA ANTITOXIN. — Curative doses, marketed in syringes containing 2,000, 3,000, 4,000, 5,000, 7,500 and 10,000 units. E. R. Squibb and Sons, New York.

GONOCOCCUS VACCINE.—Marketed in packages of six syringes each containing 500 million bacteria. Greeley Laboratories, Inc., Boston.

GONOCOCCUS VACCINE, POLYVALENT.—Marketed in separate syringe packages containing, respectively, 50, 100, 200, 400 and 1,200 million killed bacteria. Schieffelin and Co., New York.

CYMARIN.—A neutral, non-glucosidal substance obtained from *Apocynum cannabinum* and *Apocynum androsaemifolium*. Cymarin resembles amorphous strophanthin in its actions and is about equal to it in activity. It is more active when injected intravenously or intramuscularly than when given orally. Its uses are much like those of digitalis, but it is best suited in the form of Cymarin Tablets, 1-200 gr. and Ampoules Cymarin Solution containing 1-60 gr. cymarin. The Bayer Co., New York (*Jour. A. M. A.*, Oct. 17, 1914, p. 1393).

MALTINE MALT SOUP EXTRACT.—Maltine containing potassium carbonate, 1.1 gm. to each 100 gm., and alcohol 3.88 per cent. Maltine Co., Brooklyn, N. Y. (*Jour. A. M. A.*, Oct. 24, 1914, p. 1479).

MENINGOCOCCUS VACCINE, IMMUNIZING.—Marketed in boxes of 3 syringes containing 100, 500 and 1,000 million killed meningococci. E. R. Squibb and Sons, New York.

PYOCYANEUS VACCINE.—Marketed in packages of six syringes each containing 1,000 million bacteria. Greeley Laboratories, Inc., Boston.

PYOCYANO-BACTERIA.—Marketed in packages of four syringes containing, respectively, 50, 100, 200 and 400 million killed bacteria. H. K. Mulford Co., Philadelphia, Pa. (*Jour. A. M. A.*, Oct. 24, 1914, p. 1479.)

PNEUMOCOCCUS VACCINE.—Marketed in packages of six syringes each containing 500 million bacteria. Greeley Laboratories, Inc., Boston.

STAPHYLOCOCCUS ALBUS VACCINE.—Marketed in packages of six syringes each con-

taining 1,000 million bacteria. Greeley Laboratories, Inc., Boston.

STAPHYLOCOCCUS AUREUS VACCINE.—Marketed in packages of six syringes each containing 1,000 million bacteria. Greeley Laboratories, Inc., Boston.

STREPTO-BACTERIN (HUMAN) POLYVALENT.—Marketed in packages of six ampoules each containing 100 million killed bacteria; also in packages of six ampoules each containing 200 million killed bacteria. The Abbott Alkaloidal Co., Chicago.

STREPTOCOCCUS VACCINE.—Marketed in packages of six syringes each containing 500 million bacteria. Greeley Laboratories, Inc., Boston.

SCARLET FEVER TREATMENT.—Marketed in packages of four vials containing, respectively, 50, 100, 200 and 400 million killed bacteria.

SMALLPOX (Variola) VACCINE (Glycerinated).—Each dose in separate aseptic sealed glass tube, with bulb and needles. Boxes of 5 and boxes of 10 tubes. E. R. Squibb and Sons, New York.

STREPTOCOCCUS VACCINE.—Marketed in boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed streptococci; also in boxes of 2 syringes containing 100 and 500 million killed streptococci; boxes of 2 ampoules containing 100 and 500 million killed streptococci, with a syringe. E. R. Squibb and Sons, New York.

TYPHOID VACCINE, CURATIVE.—Marketed in boxes of 4 syringes containing 100, 200, 500 and 1,000 million killed bacilli; also in boxes of 2 syringes containing 100 and 500 million killed bacilli; boxes of 6 ampoules containing 100, 100, 500, 500, 1,000 and 1,000 million killed bacilli, with a syringe, and boxes of 2 ampoules containing 100 and 500 million killed bacilli, with a syringe. E. R. Squibb and Sons, New York.

TYPHOID VACCINE IMMUNIZING.—Marketed in boxes of 3 syringes containing 500, 1,000 and 1,000 million killed bacilli. E. R. Squibb and Sons, New York.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, February, 1915

Number 8

ORIGINAL ARTICLES

X-RAYS AND THEIR USE IN TREATMENT OF CANCER.*

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For years Prof. Roentgen studied the phenomena arising when currents of electricity were passed through vacuum tubes. As early as 1858 Geissler found that a glow of light was visible in tubes thus treated. In 1860 Hittorff deflected the stream of discharge in the tubes by a magnetic influence. Sir William Crooks discovered cathode rays in tubes of very high vacuum nineteen years later; and in 1894 Hertz and Leonard proved that cathode rays caused phenomena outside of the tubes.

Prof. Roentgen found that when cathode rays were stopped by their striking the walls of the tube in which they were generated, a form of radiant energy passed outside. This force was invisible but was recognized by its influence on substances which are radio-sensitive. Further, he found that these new light-rays penetrated objects of great density, and he was able to make skiagraphs with them. These were X-rays. The discovery was very soon made public and came into general use for diagnosis.

Pioneer radiologists made skiagraphs, using low power generators and soft tubes, and exposing for a long time. Soft tubes, or tubes of low vacuum, give off rays which are absorbed in the skin, producing a mild erythema or severe dermatitis, according to the quality and quantity of X-rays absorbed. These skin reactions immediately attracted attention, and studies of them showed that different tissues had different

radio-sensibility. Investigations were made to determine which tissues were most resistant, and which most sensitive, and what amount of radiation would produce a certain reaction in a certain tissue.

The pioneer radiographers themselves, suffered greatly from the handling of X-rays, which possessed dangers to them unknown. They suffered "burns" of every degree, loss of members, constitutional injury and death. But they left us a rich legacy.

My paper is an effort to present to you briefly some facts pertaining to the X-ray treatment of cancer.

X-rays are emitted from a vacuum tube through which a high tension interrupted current of electricity is passing. The quality and quantity of the rays vary with the changes in vacuum of the tube, and the amount and intensity of the current passing through the tube.

Means have been devised which enable us to vary these factors almost at will. The control of electric current has been comparatively easy, while the vacuum has been more or less variable, until a year ago, when Coolidge invented a tube, which has proved wonderful, in that it may be perfectly regulated at all times.

An X-ray tube in action emits alpha, beta, and gamma-rays. Alpha-rays are of low intensity. They are absorbed by the superficial cells on which they are projected, and they produce changes in the cells which absorb them. Beta-rays are more intense, have a slightly greater degree of penetration, producing changes in deeper layers of cells. Gamma-rays are projected deeply into the tissues or through them. They are similar in action to the active rays of radium.

*Read before the Hillsboro County Medical Society October 6, 1914.

In treating superficial pathological conditions, we use tubes emitting rays of low penetration. For slightly deeper seated conditions, medium hard tubes are more suitable, and with them screens of leather or aluminum are used to filter out the soft rays, which would otherwise cause dermatitis.

In deep therapy such screens are absolutely essential. Deep therapy is made possible and practical by the use of the Coolidge tube. With it the roentgenologist can measure accurately doses of X-rays varying from the weakest to the most massive. The Coolidge tube, however, is dangerous and should be operated only by those who are especially qualified to use it.

Doses are measured by the use of pastiles, or sensitive photographic papers which change color in direct accord with the activity of the ray. This field is still full of problems, but as a working basis we know that a certain pastile, or bromide paper, will undergo a definite color change when placed under a tube, while an erythema dose is being given. Several different scales of measurement are in use. The Holzknecht radio-chrometer or the Keinbeck instrument are in most general use. On the first, five (5) degrees or units of color-change in a pastile measures an erythema dose. The Keinbeck radio-chrometer has a standard scale, on which ten (10) degrees or X represent the least possible amount of X-radiation which will produce a mild erythema. With a reliable coil or transformer and a seasoned tube it is possible in this way to measure our doses with a fair degree of accuracy.

Many investigators have studied the radio-sensibility of different tissues, that is, the biological effect of the X-ray on the different tissues. It was found, and is accepted as a fact, that cells which are highly specialized, which have fixed functions, nerve cells especially, are most resistant to this force. On the other hand, cells which are endowed with great reproductive

activity, epithelial cells, are most sensitive to X-rays. In other words: cells which are not capable of regeneration are almost immune to the influence of X-rays, and cells which are capable of regeneration can be influenced by the rays. Furthermore, it has been found that the radio-sensibility of these cells is in direct ratio to their reproductive capability.

Therapeutic application of X-rays is made in various conditions, including many skin diseases, diseases of glands, new growths, both benign and malignant. Many radiologists report that they have had good results in treating keloid, epithelioma, psoriasis, eczema, acne, goitre, and tuberculous glands.

In malignancy a cure can not be claimed until several years have passed. My results in inoperable cases have been sometimes discouraging and sometimes most gratifying.

The fact that X-rays have a selective action on cancer cells is established and the successful treatment of cancer depends on our ability to apply the right dose to the diseased tissue, at the same time affording protection to other parts.

Theoretically, and by clinical experience, superficial cancer, rodent ulcer and epithelioma can be cured by this method of treatment. The cure will be accomplished without pain and with good cosmetic results.

When X-rays were first used in treating epithelioma, the plan of giving many small doses was followed. This, however, resulted in failure. In some cases the abnormal cells were even stimulated to rapid growth, or they gained a sort of tolerance for X-rays.

At present, with the aid of tubes of selected vacuum, radio-chrometers to measure the rays, and screens for filtering out the soft rays, the erythema dose is given at one sitting, or as near one sitting as seems wise to the individual operator. This is generally considered as suitable and sufficient for most of these superficial cases. Growths with lymphatic involvement or which are pecu-

liarily located, should be first excised or curetted and then irradiated, in order to prevent recurrence.

Second degree cancers, or those deeply seated but still so localized and situated that they may be extirpated with the contiguous lymphatic glands, should be treated surgically, but their removal should be followed by roentgenization for the purpose of preventing recurrence. Many of this class, by reason of having refused to submit to surgical treatment, have been treated by the radiologist with resulting cures.

No operable, deep cancer should be treated primarily by X-rays, but should first be extirpated and then irradiated.

Uterine fibroids, though classed as benign tumors, may become malignant, so it seems right to speak of them here.

Gauss of Freiburg has developed a special method of treating them with X-rays and it is known by his name. He does not apply it to young women nor to women whose fibroids have begun to break down or become malignant; but to cases occurring in middle life with profuse hemorrhage, his results have been remarkably good. So good that in his clinics they are no longer operated on. The X-rays are directed at the ovaries and at the tumor through many different skin areas, and an erythema dose is administered through each area at one time. The tumor shrinks and hemorrhages cease by reason of the direct effect on the tumor and indirectly by causing atrophy of the ovaries.

The technic in deep therapy must be well mastered. It requires the use of filters and tubes which give off rays of great penetration and of carefully measured doses. The Coolidge tube makes deep therapy possible and practical.

We now come to that group of cases which is considered inoperable, without hope of recovery. The growth is most frequent in regions rich in lymphatics. Often it is a recurrent one which has proved its extreme

malignancy after an operation done when conditions seemed favorable.

Richard H. Boggs of Pittsburg, in "A Plea for More Conservative Treatment of Malignant Growths," quotes John B. Murphy as saying: "An analysis of that class of cases disheartened me very much, and an analysis of the most extensive operations done in various portions of the body, later has added to my discomfort and has made the cancer field rather a hopeless proposition for me. I think we can honestly say we have not improved our cancer results in the last quarter of a century." Murphy is here referring to cancer in the regions where malignancy is most virulent. By comparison, epithelioma of the face is almost benign.

It is known that roentgenization reduces lymphatic permeability; therefore in these cases X-ray treatment should prevent metastasis and retard cancer growth. Moreover, relief from pain is one of the first recognizable results in X-ray treatment.

There is an abundance of literature in which inoperable cases have been reported cured by X-ray treatment, and other cases are reported which were at first inoperable and later so modified by treatment that it became possible for the surgeon to extirpate the malignant tissues. Again post-operative irradiation furnishes a measure which is of the greatest value in preventing recurrence or metastasis.

On the other hand, surgery and manipulation are sometimes responsible for the reappearance at a distance of the malignant process, and it is generally accepted that the recurrent cancer is more virulent in its progress than the primary growth.

Surgery needs to be humble in the face of her accomplishments with cancer and needs aid from whatever source is available.

Roentgenology offers a means of treatment which is not paralleled in any other field.

It is not the belief of radiologists that their treatments can supplant the surgical operations which are recognized, but, as I have indicated above, the X-rays must be recognized as one of the most valuable measures at our command in cancer-therapy and should be associated with the treatment in most cases where surgery is resorted to.

INTESTINAL RESECTION WITHOUT ANÆSTHESIA.

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The following case is reported to further substantiate previous statements as to the non-sensitiveness of intestine, and because it afforded an unusual opportunity to localize pain and to study the various types of pain produced by operative manipulation. No general anæsthetic, and no local anæsthesia, other than infiltration of the skin was employed.

Case H. H., white male, 52 years of age, was admitted to St. Luke's Hospital about 9 p. m., April 9, 1913, with history of having had chronic nephritis for many years. The admission examination revealed probable cirrhosis of the liver, marked abdominal ascites, arterio-sclerosis, chronic myocarditis, chronic nephritis, and there was in addition a strangulated umbilical hernia. The hernia had been strangulated for five days and there had been no bowel movement during that time. He had suffered much pain in the hernial region, and during the twenty-four hours previous to admission had had moderate fecal vomiting. One-fourth grain of morphia had been given at 5 p. m. He walked from the carriage to the hospital reception room where he went into partial collapse. After examination immediate operative relief was decided upon. The case was, obviously, not a suitable one for general anæsthesia, nor was morphine-scopolamin indicated in view of possible post-operative ileus.

The field was prepared with Harrington's solution, followed by alcohol and iodine. The skin over the hernia was infiltrated with solution of quinin and urea. The skin about the protrusion was highly inflamed.

An incision down to the sac was made without pain. The sac was highly inflamed, black and gangrenous, and intimately adherent to the surrounding tissue; it was thoroughly exposed and isolated; the patient complained bitterly during this procedure, not apparently from manipulation of the sac but from the cutting and tearing of the adjacent subcutaneous tissue. A small puncture was made in the sac without pain. A gush of serum followed. Digital examination revealed the presence of a thickened loop of bowel; no omentum was present.

The sac, which was nearly a half inch in thickness, was laid widely open without pain, due, no doubt, to its gangrenous condition. Approximately six inches of jejunum was constricted and plainly gangrenous. In cutting the constricting ring of fascia and healthy peritoneum the patient stated that he felt moderately severe pain of a burning character and that it was localized at the point of incision. Approximately three gallons of fluid were withdrawn from the abdominal cavity.

The gangrenous bowel was pulled gently out of the abdomen, together with about six inches of healthy gut on each side of the pathologic portion. Undue tension on the mesentery caused a cramp-like pain, which was referred to the epigastrium. No pain was felt, either upon severe pinching of the gangrenous or normal bowel. The patient stating that there was absolutely no sensation from pinching the healthy bowel with forceps, double clamps were accordingly placed and the bowel divided. No pain was manifested during this procedure, the patient entering into the spirit of our investigation and following closely the progress of the work.

A V-shaped piece was removed from the mesentery. Each time a clamp was placed on the mesentery, and each time a ligature was tied the patient complained of severe pain referred to the epigastrium as it was when the mesentery was pulled upon. He stated that the pain was not unbearable, that it was of a colicky or cramp-like character, indeed that it felt like the "green apple" colic that he had had in childhood. The pain occurred just at the moment of closing the clamp, or tightening of the suture, it did not persist, and that portion of the mesentery distal to the clamp soon became analgesic. The divided ends of the bowel were united by a Murphy button, reinforced by a continuous Lembert suture of silk. No pain was felt, the patient was absolutely comfortable and talked cheerfully. We were careful not to place tension on the mesentery.

Experimentally, a loop of gut several feet away from the anastomosis was tested for sensation. It was pinched and stretched laterally and longitudinally without actual injury, no pain or other sense of feeling being experienced. Even moderate tension on the mesentery caused pain referred to the epigastrium; handling and gentle pinching of the mesentery was felt as an indescribable "gone feeling" in the pit of the stomach. A moderately strong pull on the mesentery seemed to "take his breath away."

The bowel was returned to the abdomen; the base of the sac was closed with mattress sutures and the sac cut away. The fascia was closed with chromic gut, and the skin sutured with silk worm gut. Again the patient complained of severe pain during the sewing of the peritoneum, and of stinging pain during the suturing of the skin.

At the end of the operation he was in a greatly improved condition and stated that he was free of all pain other than a slight local tenderness. He had absolutely no shock; the pulse and facial expression had improved; he said that he felt "like a colt" and offered to walk from the operating

table to the third floor. It required quite some argument on our part to convince him that it was best for him to be carried.

He did well for six days. His bowels acted with low enemas after the first day, and twice daily thereafter. Severe hiccough, with symptoms of kidney disturbance began on the seventh day. The secretion of urine lessened rapidly until on the tenth day he secreted but two ounces. He died in uremic coma April 22, 1913, thirteen days after operation.

Post-mortem examination revealed the anastomosis intact. The button had not passed. It was free but was held about two inches from the anastomosis by a strand of the silk reinforcing suture. This may account for the delay in the expulsion of the button so often noted in similar cases.

The principal practical deduction to be made from this and similar cases is that shock is almost always entirely absent. Under full general anæsthesia more or less shock, following such an operation, does not surprise us. Such cases certainly afford a strong argument in favor of local anæsthesia in strangulated hernia, and in other types of gastro-intestinal surgery wherever it is possible to use it, and fortify the practice of some surgeons in maintaining full general anæsthesia during the opening and closing of the abdominal wall, but allowing the patient to practically come out during the work upon the stomach or intestine.

Summary.

1. The parietal peritoneum is extremely sensitive.
2. There is no sensation in the bowel proper.
3. The mesentery is extremely sensitive to traction and pressure.
4. Pain concurrent with distended bowel is probably due to traction on the mesentery.
5. Shock does not follow gentle handling of bowel.
6. Shock in abdominal operations is probably due to the general anæsthetic plus

mesenteric tension from direct traction or pressure by packs.

7. Strangulated hernia may be relieved without shock under local anæsthesia.

8. In all work upon the gastro-intestinal tract anæsthesia should be full during the opening and closing of the abdominal wall, but should be as light as possible during the actual work on the gut.

SYPHILIS OF THE ORAL CAVITY.*

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Jacksonville, Florida.

To discuss as broad a subject as syphilis from a general standpoint within the time usually allotted an essayist for a paper of this character would, no doubt, be time ill spent. We will therefore confine our remarks this evening to the manifestations of syphilis in the region of the head or more especially the oral cavity.

The statistics of syphilographers with reference to the percentage of syphilitics, vary in different countries, but I should say that at least 10 per cent of any community is infected with this disease and not a few have the disease who do not know it or recognize it as such.

With your knowledge of the number of people who consult the dental surgeon, whether it be 50 or 100 per cent of a given community, you should bear in mind that while all syphilitics are not actively infectious, dental surgeons meet a large number who are. On account of the treatment the syphilitic has taken, that is to say mercury which has resulted in ptyalism, gingivitis and dental caries, not a few consult the dentist.

Syphilis, as you all know, is a chronic blood infection from its inception. The spirochetæ pallida or, more properly speaking, the treponema pallida have invaded the tissues of the body weeks and sometimes months be-

fore you find lesions of the mucous membranes or sores in the mouth and throat.

As we have just stated, acquired syphilis is due to the entrance of the spirochetæ through a small abrasion into the skin or mucous membrane of the healthy subject through contact with a syphilitic sore; after entrance into a healthy subject they multiply very rapidly and show a marked tendency to accumulate in the skin and mucous membranes in large numbers, especially in the mucous membranes of the nose, mouth and throat. These accumulations are what we see in any syphilitic ulceration and know as syphilitic lesions, whether they be primary sores or chancres, secondary ulcers or tertiary gummata.

In the mouth the favorite sites for these lesions are the angles, and on the cheeks opposite the upper molars. Mucous membrane ulcerations are more apt to be seen in the acquired form rather than in the congenital or hereditary type of the disease. The most marked evidence of hereditary syphilis is known as Hutchinson's triad, all being head symptoms. They are the notched teeth (always the permanent central upper incisors), the eye and ear symptoms. These notched or peg teeth are pathognomonic of hereditary syphilis, a condition which every dental surgeon should recognize. As the teeth are a part of the dermo-skeleton they suffer along with the skin in this disease; however, a mercurial stomatitis will also affect the growth of the teeth, but you may differentiate mercurial teeth from syphilitic teeth by examination of the so-called test teeth. These test teeth are (1) of syphilis—the upper central incisors; (2) of mercury—the first permanent molars.

The upper central incisors are usually short and narrow with a broad vertical notch in their edges with corners rounded off.

The next and most prevalent syphilitic manifestation that you as dental surgeons are apt to meet, are the ulcerations of the

*Read by invitation before the Jacksonville Dental Society, October, 1914.

tongue, mucous membranes of the mouth, tonsils, and fauces both primary and secondary. As you know syphilis has been divided, for the purposes of description, into three stages. The first stage that of the chancre or initial lesion; second, the stage of skin eruption and mucous ulceration; third, the stage of gummatous ulceration. In the first stage we have to differentiate chancre of the lip, mouth and tongue from cancer and tuberculosis. Cancer is rarely seen before the age of forty while chancre is seen in the young. Cancer bleeds more easily, the surface is irregular, the edges are thick, advance is slow, and the glands in the neck enlarge only after months, while the syphilitic sore has a flat surface, rarely has smooth edges and the glands enlarge in a week or ten days.

Chancre of the lip and tongue is to be differentiated from ulcer due to a ragged tooth and tuberculosis which is very rare. The ulceration in tuberculosis is irregular in outline, extremely sensitive and always multiple, usually situated under the tongue and nearly always associated with tuberculosis elsewhere.

The mucous membrane lesions of the second stage are the ones most often met with and are the most infectious. The ulcerative types are most common during the first three years of the disease. The syphilitic papule on a moist mucous membrane is always eroded. The erosion is the most deceptive of all lesions of the mucous membranes, in that it may or may not be painful, appear and disappear in a day or two, with or without treatment, varies in size from a pinhead to a split pea or even larger, and may appear in groups or singly, while most any application will cause them to disappear for the time being; consequently, by inspection or, as we say, clinically, there is no way to differentiate these lesions from stomatitis.

The eroded papule, however, is characteristic of syphilis. It is circular, dark red in color, and varies in size from a split pea to a ten-cent piece. The ulcerative syphilide

may occur as a simple ulcer, may be superficial or deep, and varies in size and shape. In the mouth you will usually find them in the angles which are more or less fissured in the pillars of the fauces, and on the tonsils.

These ulcers are to be differentiated from (1) mercurial stomatitis, from which it is impossible to draw definite conclusions, but generally speaking mercurial ulcers are found on the cheek or gums opposite the last molar tooth or the gums around the upper central incisors, never at the angles of the mouth or on the fauces. These with other evidences of mercurialism as salivation may offer some help from a clinical standpoint; (2) from aphthous stomatitis in which the lesions are always small and very sensitive, while in syphilis the lesions are more extensive and are not sensitive, (3) from herpes of the mouth which occur as small whitish papules and are distinguished from the syphilitic sore by the small size of the individual lesion, and their frequent grouping surrounded by a white collarette.

Other lesions of the mouth which may occur and which are indistinguishable from mucous patches are thrush, hydroa and burns.

In the third stage the tertiary lesions of the lips, mouth, tongue, soft and hard palate are known as gummatous ulceration and come on late in the disease. The lips may show a thickening without ulceration—however ulceration may occur. The tongue is the seat of several tertiary lesions; we may mention first what is known as leukoplakia or milk spots on the tongue; you will notice a milk white spot on the tongue which is painless and unattended by inflammation; this is almost invariably specific and you may look with suspicion on any accompanying ulceration you may find in the mouth.

Gumma of the tongue is usually situated on the dorsum and never on the under surface, appears as a deep ulcer and is associated as a rule with sclerosis or a hardening of the organ. The distinguishing feature

from cancer of the tongue is that in cancer the discharge is foul smelling, the ulceration painful and comes on late in life, while in syphilis there is little or no pain, the disease may occur at any age and the discharge is without odor.

The tertiary lesions of the palate and tonsils appear as infiltrated ulcers with a tendency to perforate. A perforating ulcer of the soft palate is always of syphilitic origin.

From the foregoing it is plainly evident that, from a clinical standpoint, that is where we depend on inspection alone, in dealing with ulcers of the mouth, tongue and throat we can only make a tentative diagnosis. Realizing therefore the difficulty of diagnosis (without laboratory aid) and realizing the infectiousness of specific or syphilitic sores, we should look with suspicion upon every ulcer with which we come in contact, for a number of people are infected with syphilis who are not themselves cognizant of that fact, while large numbers of known syphilitics deny infection to any one excepting their medical advisor. All of the former class and a large number of the last named group are of course a menace to all with whom they come in contact.

From the standpoint of the dental surgeon, as a matter of self-protection, it certainly behooves him to exercise extreme caution when dealing with any mouth which presents an ulceration no matter how small or innocent it may appear. I may mention in this connection that I have seen two dentists in the past two years with chancres on their fingers.

As to the length of time the germs in the secretion from syphilitic ulcers cease to be infectious, if moist about twelve hours, if dry not over six hours and a syphilitic germ can live in water only about one minute. The most powerful prophylactic after contact with a suspicious ulcer is a 20 per cent ointment of the mild chloride of mercury.

In conclusion, gentlemen, I wish to summarize a few points regarding syphilitic sores of the mouth:

1st: It is practically impossible by inspection alone to differentiate syphilitic from nonsyphilitic sores and is only possible by means of laboratory methods.

2nd: It is a safe rule to look with suspicion upon every ulcer of the mucous membrane of the mouth, throat and tonsil.

3rd: Syphilitic ulcers of the mucous membranes of the mouth are highly contagious, in fact the most contagious of all specific ulcers.

4th: In view of these facts it should be the duty of every physician who has knowledge of this condition in a patient, to confer with the dentist regarding the infection when referring him for dental work.

THE ROLE OF PYORRHOEA IN THE ETIOLOGY OF NERVOUS AND MENTAL DISEASES.

JAMES H. RANDOLPH, M. D.,
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By the term "Pyorrhœa," as used in this paper, is meant that acute or chronic inflammatory condition of the gingival tissues due to microbic invasion of various sorts, and characterized by a spongy, swollen, reddened and bleeding condition of the gums with or without pus freely flowing on pressure, or else (the later stages) shrunken alveolar processes, wasted gingival tissues, teeth more or less loosened or skeleton-like and pus more or less freely expressible from around the bases.

By the expression "Nervous and Mental Diseases" is included that wide range of conditions characterized by disturbances both anatomical and physiological, one or the other, of the brain, spinal cord or peripheral nerve; "mental" disease being really "brain" disease—whether organic or functional, and "nervous" diseases including affection of the cord and spinal nerves—aye, and more than

the spinal nerves, unless one has been taught to include in the term "spinal nerves" that extensive and most important though long neglected system of nerves formerly called sympathetic or vasa-motor and now better known as the autonomic. For, as it will be my pleasure to point out to you later, it is to disturbances or affections of this unrecognized or forgotten system of nerves that we must charge that very large number of cases coming to us with the diagnosis of neurasthenia.

These disturbances or affections, as we all know, may be both organic or functional; the organic conditions comprising those in which there has been actual loss or disruption of tissue, and the functional ones including those in which there is only disturbance of function without any actual loss of tissue substance.

Likewise, the relation which pyorrhœa may bear to these conditions is twofold. It may, by direct extension of the micro-organisms responsible for the pus around the gums, give rise to a serious meningitis or encephalitis, or even to a brain abscess localized but none the less disastrous. I have not yet had an opportunity to observe a case of the latter type; but as an example of the former I may refer to the case record of A. J. B., referred to me in January, 1914, with a history of backache and headache with steady albeit recently increasing malaise and disability until at the time he came under my personal observation, he was in a state of mental torpor with delusions and hallucinations of a depressed type, emotional, restless and confused. Physically a large powerful man, he had the appearance of being ill, looked anemic and poorly nourished, but with a blood count approximately normal except for a slight increase in total leucocytes. Temperature irregular and ranging from 97.5 to 99.5, once or twice reaching 100.0; pulse rate varying from 70 to 90 and depending more upon the emotional state apparently than the temperature curve, tongue furred, breath foul, extensive and intense

pyorrhœa, bowels constipated, reflexes sluggish (both superficial and deep), no marked sensory nor motor defect, heart and lungs normal and examination of urine and spinal fluid negative except for a very slight increase of albumen and small white cells in the latter—perhaps enough to make one suspicious of a possible tabes or paresis, but in the face of a negative Wasserman both for blood and spinal fluid should be discounted. Believing that the condition which presented was one due entirely to a general toxemia from the bacterial invasion of the oral cavity, with direct extension of the infecting organisms back through the blood or lymph channels to the cerebral tissues, treatment was instituted accordingly and conducted solely along this line with perfect results both as to the relief of the infection (locally) and the clearing up of the mental symptoms. The one factor needed to complete the chain of evidence in this case, and show absolutely the relation of the pre-existing pyorrhœa to the more recent mental disturbance or brain disease was the culturing of the spinal fluid to identify any growths that might have been recovered with the growths found in the pyorrhœa and used in the autogenous vaccine with which the case was treated.

If we concede that the organisms producing the pyorrhœa may and do by direct extension invade the nearby or adjacent nerve tissues and structures, it is but a step further to look for a similar invasion and consequent affection of more remote tissues including nerve trunks. George Dock pointed out to us the direct relationship existing between the chronic rheumatic affections, particularly arthritis deformans and pyorrhœa infections, and I am frank to say that the same relationship may exist toward certain forms of neuritis—both sensory and motor—namely transplanting of the infection through the blood stream and production of a low grade of inflammation along the nerve trunk with resultant pain, hyperesthesia, paresthesia, or anesthesia, and loss of motion.

Post-diphtheritic paralysis or palsies have long been recognized as due to the extreme toxicity of the infecting micro-organisms, and post-typhoid psychoses accepted as one of the untoward sequelæ of that infection, as also does the condition known as neurasthenia so often follow influenza infection. Different bacterial toxins seem to have affinity for different nerve tissues, just as lead and alcohol appear at times to exert almost selective action in their effects, and where definite infection of nerves or nerve trunks can not be shown, the same toxic action (more or less "selective," it may be) can also be attributed to the infecting organisms of pyorrhœa. Such presumption is justified only as clinical evidence or cases accumulate; and from a series of over twelve cases lately coming under my observation, I have selected one or two as examples of different types of the condition which would support this view.

Case 1. H. F. Mc., builder and contractor, married, middle aged; no evidence of syphilis; moderate user of alcohol, previous excessive use of tobacco, which however had been discontinued in course of treatment and advice he had been following for relief of a "Chronic Sciatica." Physical examination revealed no organic disorder, the man being strong and active except for the disability caused by his sciatica. He was treated symptomatically and lost sight of for about a year when he returned complaining of a painful condition of the shoulder with limitation of motion especially abduction and numbness and tingling often felt down the ulnar side of the arm to the fingers. Examination revealed practically the same condition physically with exception that his temperature was very slightly elevated—99; and the blood showed a white cell count of about 10,000, and there was distinct tenderness on pressure over the nerve trunk in the arm.

The only nidus or source of infection which could be found on this patient was a pyorrhœa which had not been previously

stressed but which seemed at this examination to be more profuse than before. The suggestion was made to the patient that this was doubtless the cause not only of his present trouble but also of his previous sciatica, his co-operation and that of his dentist secured; general treatment (so-called "anti-rheumatic") given for the relief of the neuritis, including vaccines, both stock and autogenous; all of which was followed by prompt recovery and no return for a period of two years to date.

Case 2. J. P. L., referred to me in July, 1913. The man had been under treatment for two months or more for a trouble that presented almost all the textbook symptoms of "Poly-neuritis," and at the time that I saw him was bed-ridden, emaciated, still suffering however various paresthesias, hyperesthesias and anesthetics, impaired reflexes, etc. No history of alcohol, syphilis or drugs, and Wasserman negative to both serum and spinal fluid, which latter was also negative to any findings suggestive of central lesion. Here again physical examination was negative except for the general muscular weakness and atrophy; but his chart showed an irregular temperature curve and the blood picture was one suggestive of a primary anemia with white cell count from 10,000 to 12,000—suggestive of some low grade infection.

Again, as in the case above, the only nidus of infection or source of toxemia to be found was in a distressing pyorrhœa which the patient stated had long been there, but which he had never thought of paying any special attention to. Again the possible relationship was explained to him, autogenous vaccines made, dental assistance secured and general treatment instituted, with the result that all acute symptoms subsided, and his general condition improved to the extent that he could get out and about and returned to his home in a distant state to complete the convalescence.

Such instances could be multiplied many-fold no doubt in the experiences of the men

in general practice, and I myself have case records of a dozen or more all so strikingly alike in the findings and the relief directed along these lines that I have felt it almost conclusive evidence of the correctness of my views and the rationale of the treatment as sufficiently valuable to call it to the attention of the medical profession at large.

PROPAGANDA FOR REFORM.

AGAR-LAC.—Agar-lac, sold by E. Fougere and Co., is stated to be composed of "Agar-Agar with Lactic Ferments Grs. 4 1-2, Phenolphthalein Grs. 1-2." Regarding the "lactic ferment," the expert of the Council on Pharmacy and Chemistry reported that *Bacillus bulgaricus* were present in small numbers only and that there were at least two other bacteria present. The Council refused recognition to Agar-lac because its composition is not correctly declared, because it is exploited in a way to cause laymen to use it to their detriment, because unwarranted therapeutic claims are made for it, because its name does not indicate the most potent constituent, phenolphthalein, and because the use of a ready-made combination of cathartic drugs with lactic acid ferments is unscientific. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1777.)

ALBORUM.—Alborum is sold by the Whitehouse Chemical Co., Lynchburg, Va., and is stated to contain boric acid, alum, phenol and oil of peppermint, the amounts not being declared. This preparation lacks originality and is unscientific. Its exploitation being held contrary to the best interests of the public and the profession, Alborum was refused recognition by the Council on Pharmacy and Chemistry. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

APERGOLS.—Apergols, put out by H. K. Wampole Co., Inc., is apparently an inversion of the name Ergoapiol and the preparation appears to have essentially the same formula. In general the claims made for Apergols are the same as those made for

Ergoapiol. The Council refused admission to Apergols because they are advertised indirectly to the public, because of unwarranted therapeutic claims, because of the non-descriptive name and because the product is unscientific. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

ASEPTICONES.—Asepticones, sold by the Chinosol Company, are vaginal suppositories stated to contain salicylic acid, boric acid, quinin and chinosol. On the basis of the evidence submitted the Council on Pharmacy and Chemistry voted that Asepticones be refused recognition because unwarranted and misleading therapeutic claims are made; because the name does not indicate the potent constituents and because it was considered an unscientific shotgun mixture. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1778.)

BACILLICIDE.—Bacillicide, sold by the Prophtol Products Company, Richmond, Va., is an unscientific solution of the Glyco-Thymoline type. It was refused recognition by the Council on Pharmacy and Chemistry because its composition is secret, because unwarranted and exaggerated claims are made for it and because the use of complex mixtures of uncertain composition is unscientific and contrary to the best interests of the public. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1778.)

BETUL-OL.—Betul-ol is a methyl salicylate preparation advertised by E. Fougere and Co., New York, to physicians and, indirectly to the public, as an eternal analgesic and antirheumatic. It was refused recognition by the Council on Pharmacy and Chemistry because the statements regarding its composition are vague, misleading and incorrect, because unwarranted therapeutic claims are made for it, because the recommendations are likely to lead the public to the self-treatment of rheumatism, with serious consequences. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2148.)

GASTROGEN TABLETS.—These tablets, recommended by the Bristol-Myers Co., New York, to be used in connection with its other nostrum, Sal Hepatica, are said to contain pepsin, calcium carbonate, calcium phosphate and "aromatics." As patients who need an antacid do not need pepsin and vice versa the preparation is unscientific and the therapeutic claims made for it unwarranted. Gastrogen tablets were refused recognition by the Council on Pharmacy and Chemistry. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

CYSTOGEN, CYSTOGEN APERIENT AND CYSTOGEN-LITHIA.—Cystogen is the therapeutically suggestive name applied to hexamethylenamin by the Cystogen Chemical Company, St. Louis, Mo. By means of extravagant claims, unwarranted assertions and pseudo-scientific arguments the Cystogen Chemical Company advises the use of Cystogen Aperient or Cystogen-Lithia or all three in a well nigh endless number of diseases. The promoters take care that every Cystogen prescription is likely to spread the Cystogen gospel among the people. In announcing the rejection of these products the Council on Pharmacy and Chemistry calls attention to the conservative discussion of hexamethylenamin which appears in its publication "Useful Drugs." (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

CYSTO-SEDATIVE. — Cysto-Sedative (Strong, Cobb and Co., Cleveland, Ohio) is said to contain thuja occidentalis, pichi, saw palmetto berries, triticum repens and hyoscyamus. Cystogen-Sedative was refused recognition by the Council on Pharmacy and Chemistry because unwarranted and preposterous claims were made in regard to its preparation and because unwarranted therapeutic claims were made for this unscientific mixture. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

CYPRIDOL CAPSULES.—Cypridol capsules, sold by E. Fougera and Co., New York, are stated to contain mercuric iodide dis-

solved in oil. The Council on Pharmacy and Chemistry refused recognition to Cypridol capsules because they were sold under unwarranted therapeutic claims and because they were marketed in a way to appeal to the public. If the capsules are once prescribed the directions on the bottle and the full instructions for the treatment of syphilis which accompanies the bottle is likely to lead the patient to attempt to treat his malady on his own accord and thus probably forfeit his chances of a cure. Physicians who want to use a solution of mercuric iodide in oil, should have their pharmacist prepare it for them. (*Jour. A. M. A.*, Dec. 19, 1914, p. 2247.)

ECKMAN'S ALTERATIVE.—Eckman's Alterative is a "consumption cure" patent medicine consisting essentially of alcohol, calcium chlorid and cloves. Now the Eckman concern is running a series of advertisements in which medical writings on the use of calcium in tuberculosis are twisted into recommendations for the nostrum. (*Jour. A. M. A.*, Nov. 7, 1914, p. 1686.)

ERGOAPIOL. — Ergoapiol (Martin H. Smith Co., New York) is a mixture put up in capsules, each of which is said to contain Apiol (Special M. H. S.) 5 gr., Ergotin 1 gr., Oil Savin 1-2 gr., Aloin 1-8 gr. Examination indicated that each capsule did not contain 5 gr. apiol but an oleoresin of parsley seed. The recommendations in the advertising matter invite its indiscriminate use. The Council on Pharmacy and Chemistry refused to recognize this unscientific mixture of ingredients which has widely differing therapeutic effects. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

HEMO.—The Thompson Malted Food Company, Waukesha, Wis., which sells Hemo, Malted Milk and Malted Beef Peptone, offers its stock to physicians with promise of large profits. Hemo is advertised as "the food that builds up weak stomachs" and is stated to contain "the iron of spinach, the juices of prime beef, the

tonic properties of selected malt in powdered form and the richest sweet milk." Hemo is "promoted" by absurdly extravagant claims and pseudo-scientific nonsense. Disregarding the question whether or not this is a stock jobbing scheme or whether the purchase of the stock is a good investment, physicians who buy the stock and prescribe the firm's output are not giving their patients a square deal. (*Jour. A. M. A.*, Oct. 24, 1914, p. 1494.)

INTESTINAL ANTISEPTIC W-A.—The Abbott Alkaloidal Co., advertises Intestinal Antiseptic W-A as "... A scientifically blended and physiologically adjusted mixture, of the pure sulphocarbolates of calcium, sodium and zinc, grs. 5, with bismuth subsalicylate, gr. 1-4, and aromatics." The Council on Pharmacy and Chemistry refused recognition to this proprietary because the formula does not indicate the proportionate amounts of the several sulphocarbolates, because the name is therapeutically suggestive and an invitation for the use of the preparation by the public and because exaggerated therapeutic claims are made for it. The claims which are made are most extreme; they contrast sharply with the low esteem in which the phenolsulphonates (sulphocarbolates) are generally held. It does not appear that the claims have been substantiated by proper evidence. (*Jour. A. M. A.*, Dec. 19, 1914, p. 2247.)

IODIA.—Iodia (Battle and Co.) is claimed to contain potassium iodid in combination with iron phosphate and vegetable "principles." It is extravagantly recommended for use in many and varied conditions. It is asserted to be "almost a specific" in eczema and rheumatism and a "highly efficient form of iodine." The A. M. A. Chemical Laboratory having shown that untrue statements in regard to the composition and preparation are being made, the Council on Pharmacy and Chemistry refused recognition to Iodia on this account; because unwarranted therapeutic claims were

made and because the use of this complex mixture is unscientific and a detriment to the profession and the public. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1871.)

IODALIA.—Iodalia (Geo. J. Wallau, Inc.) is claimed to be a valuable substitute for iodides. Examination in the A. M. A. Chemical Laboratory indicated that when administered it would act like ordinary iodides and that to obtain the equivalent of 20 gr. potassium iodide it would be necessary to give the contents of a one dollar bottle of Iodalia. Particularly reprehensible among the many unwarranted claims made is one which suggests to the public that Iodalia will protect against infectious diseases. The Council voted that Iodalia be refused recognition. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

IODOTONE.—Eimer and Amend, who market Iodotone, state that it is a glycerin solution of hydrogen iodide, containing 1 gr. iodine to each fluid dram. While Iodotone must act like ordinary iodides and while nearly one ounce of glycerin must be swallowed to obtain the equivalent of 10 gr. potassium iodide, the unwarranted claims are made that Iodotone is superior to iodides. Because of misleading claims and because the name Iodotone is likely to suggest its use as a general tonic, Iodotone was refused recognition by the Council on Pharmacy and Chemistry. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2149.)

IRON SOLUTION FOR INTRAVENOUS THERAPY.—This solution, manufactured by Perkins and Ross, Colorado Springs, Colo., contains soluble iron phosphate as its essential constituent and is recommended as a "chalybeate, emmenagogue and tonic." As the intravenous administration of a drug like iron, which must be continued for long periods, cannot be considered the method of choice, as the composition of the solution is such that changes may occur on standing, etc., which would make the preparation dangerous, and as the method of

marketing the solution does not insure its sterility, further increasing the danger of its use, the product was refused recognition by the Council on Pharmacy and Chemistry. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1778.)

KELLER'S TUBERCULIN TEST PLATE.—This appears to be an attempt to exploit the Moro tuberculin ointment. The test does not discriminate between active and latent tuberculosis. As most adult persons have experienced tubercular infection at some time in life, a large majority of persons will respond positively to the test. (*Jour. A. M. A.*, Dec. 19, 1914, p. 2250.)

LYSOFORM.—Lysoform and Crude Ysoform, made by the Lysoform Gesellschaft, Berlin, Germany, are solutions of potash-soap stated to contain respectively 6-7 and 10 per cent. of formaldehyde. These preparations were refused recognition by the Council on Pharmacy and Chemistry because unwarranted claims were made in regard to their efficiency and because their indiscriminate use for the treatment of diseases was recommended. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1870.)

MAIGNEN ANTISEPTIC POWDER.—This powder, exploited by the Maignen Institute, Philadelphia, is stated to be composed of calcium hydroxid, sodium carbonate, aluminum sulphate and boric acid and its action depends on the sodium hydroxid which forms when the powder is treated with water. It is advertised both to physicians and the public by means of claims which are extravagant, preposterous and dangerous. Thus a pamphlet gives directions for the sterilization of the nose, throat, stomach, lungs, eyes, gums, mouth and the genito-urinary tract. Its use is claimed to prevent blood poisoning, lockjaw, hydrophobia and infectious diseases and mothers are invited to treat their babes' ailments with it. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1778.)

NARCOPHIN.—Narcophin consists of morphin meconate and narcotin meconate in

molecular proportions. It is claimed to be a scientific substitute for opium and to have advantages over morphin. The Council on Pharmacy and Chemistry was unable to accept the therapeutic claims made for it. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1872.)

NOURRY WINE.—This wine, sold by E. Fougere and Co., is said to contain 12 per cent. alcohol and 1 1-2 gr. iodine to the fluidounce in combination with tannin. Examination in the A. M. A. Chemical Laboratory showed that its action would be that of ordinary iodide and that the non-production of iodism is due to the small amount of iodine it contains. Claims are made which are prone to lead to its use both by the profession and the public in conditions in which effective medication is called for. The Council on Pharmacy and Chemistry refused recognition to Nourry Wine. (*Jour. A. M. A.*, Dec. 12, 1914, p. 2150.)

PAPINE (BATTLE AND CO.).—This is a simple aqueous alcoholic solution of morphin, 1 grain to each ounce. It is exploited under the utterly unwarranted claim that it does not nauseate, constipate nor create a habit. (*Jour. A. M. A.*, Oct. 17, 1914, p. 1411.)

PHECOLATES, PHECOLAX, PHECOZYMES AND PHECOTONES.—These are tablets put out by F. Waldo Whitney designed to form part of a system of treatment founded on the theory of autotoxemia. The different mixtures consist in the main of well-known remedies, one of them containing ten constituents. Most extravagant claims are made for these mixtures. The Council on Pharmacy and Chemistry voted to refuse them recognition as unscientific shotgun mixtures and because the names do not indicate their potent constituents. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1870.)

RADIUM EMANATION ACTIVATORS.—Outfits for charging drinking water with radium emanation are now widely and extravagantly exploited. For an apparatus which imparts 2500 Mache units to water each

day as much as \$200 is asked. Theoretically, 72 cents worth of radium can produce 2500 Mache units of emanation per day. Even if, because of mechanical difficulties, 20 times as much radium were required to be present in the activator, the cost of the radium in this \$200 apparatus would be only \$14.40. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1780.)

SERUM VACCINE, BRUSCHETTINI.—This vaccine, sold by R. G. Berlingieri, New York, has for its aim the destruction of the tubercular cell and the facilitation of its elimination by the natural expulsive processes. The manufacturer not having submitted proof of the value of the preparation, the Council on Pharmacy and Chemistry voted that it be refused recognition. Later, information was received that the preparation was now used only in slight cases. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1870.)

SHERMAN'S NON-VIRULENT TUBERCLE VACCINE.—This product of G. H. Sherman, Detroit, was refused recognition by the Council on Pharmacy and Chemistry because the far-reaching claims made for it were not substantiated by suitable evidence. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1870.)

THE ACTION OF IODIDS ON BLOOD VESSELS AND HEART.—The iodids, especially potassium iodid, have been credited with having a blood-pressure lowering action and have been used extensively in the treatment of arteriosclerosis. D. I. Macht has demonstrated that the iodid ion, instead of depressing the heart and vessels, has a marked stimulating action and that if potassium iodid lowers blood-pressure it must be the effect of the potassium part of the compound. (*Jour. A. M. A.*, Nov. 14, 1914, p. 1767.)

THE FRIEDMANN TREATMENT.—An investigation made by the U. S. Public Health Service of the validity of the claims made for the Friedmann treatment of tuberculosis is a complete refutation of Dr. Friedmann's claims, not only as to having developed a

specific cure for tuberculosis but also as regards the harmlessness of the treatment. The report of the investigation shows the flimsy evidence on which the Friedmann method for the treatment of tuberculosis was based. (*Jour. A. M. A.*, Nov. 7, 1914, p. 1673 and 1690.)

UNGUENTUM SELENIO VANADIC, v. ROEMER.—This ointment, marketed by Schering and Glatz, New York, is claimed to contain selenium oxycyanid and vanadium chlorid. No evidence of the value of the preparation either in carcinoma or in any of the very long list of other diseases in which it is recommended was submitted. The pharmacologic evidence that such a preparation would be of value in such conditions being practically nil, the Council on Pharmacy and Chemistry refused recognition to the product. (*Jour. A. M. A.*, Nov. 21, 1914, p. 1870.)

USE OF PARAFFIN OIL.—While it is recognized that cancer may be caused by chronic irritation, the paraffin oil used medicinally is bland and non-irritating and there is no reason to suppose that its continued use would cause cancer. A good quality of oil may be obtained by prescribing *Paraffinum Liquidum* or *Petrolatum Liquidum Grave*. (*Jour. A. M. A.*, Oct. 17, 1914, p. 1411.)

WARNER'S SAFE REMEDY.—"Warner's Safe Remedy for the Kidneys and Liver and Bright's Disease" is reported by the A. M. A. Chemical Laboratory to contain alcohol, by volume, 14.40 per cent., glycerin, by weight, 7.72 per cent., potassium nitrate 1.75 per cent. and vegetable extractives. This preparation consists essentially of alcohol and potassium nitrate. Alcohol is contra-indicated in inflammatory diseases of the kidneys and potassium nitrate is a kidney irritant. Sufferers from kidney diseases who take Warner's Safe Remedy will shorten their lives. (*Jour. A. M. A.*, Dec. 19, 1914, p. 2246.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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THE DANGER OF DELAY IN CANCER.

"Thousands of lives now needlessly sacrificed to cancer could be saved if the patient would go to the surgeon as promptly as does the average person attacked by appendicitis. Nor is there any reason why the cancer patient should not seek this, the only safe treatment, with the same high degree of confidence in the outcome that is now common among those suffering from the other more fashionable disease. Unfortunately, the evidence is only too clear that a different attitude toward cancer prevails and occasions many preventable deaths. The almost superstitious dread of the disease and unwillingness to admit its existence or to seek medical advice in time are well known and difficult obstacles to progress in its control. Proof of this fatal neglect is found in the experience of a prominent surgeon who recently studied his case records in order to obtain definite information as to the delay in the average case. Of 65 recent patients, 35 were men and 30 were women. Further study of these 65 cases showed that after the first discovery of suspicious symptoms the men had waited an average of 12.2 months before consulting the doctor, and the women had waited, on the average, 11.9 months, practically a year's delay in all cases. Many other surgeons could produce very similar records. Winter, of Koenigsberg, Prussia, the pioneer in the education of the public in regard to cancer, examined the records of 1,062 operable cases and showed that 87 per cent of these patients could and should have applied for treatment much earlier, when they would have had a far higher chance of recovery than was actually the case.

To the delay when the symptoms are manifest must be added the previous indefinite period after the beginning of the disease and before the patient realizes the trouble. This period can be shortened by education. Fortunately, the symptoms of cancer are present quite early and can

usually be recognized if the patient understands their importance. In too many instances, however, the disease is not suspected until the symptoms are pronounced or until there is a tumor of considerable size. If we assume that this period averages six months, and then add the year's delay for which the patient is responsible, we find that the average patient does not seek advice until at least a year and a half after the onset of cancer. This precious time, thrown away, means, if not a fatal outcome, at least a serious instead of a minor operation.

In the present state of our knowledge of malignant disease it can not be too frequently emphasized that the hope of curing cancer is to be found in its earlier recognition and in prompt and competent surgical treatment. The unfortunate patient who, because of ignorance or unwarranted fear or the blandishments of quacks, hesitates to seek proper advice should realize that in this delay he or she is recklessly throwing away a splendid chance of cure."

U. S. PUBLIC HEALTH SERVICE REPORT ON A TUBERCULOSIS TREATMENT.

"The investigation of the von Ruck treatment for tuberculosis that was being made by the Public Health Service in response to a resolution of the United States Senate has just been made public as Senate Document 641. This follows close on the report from the same service on the Friedmann treatment, and, as in the latter, the verdict has been that von Ruck's claims have not been substantiated.

"On account of the evident practical difficulties in carrying out the studies on human beings," says *The Journal of the American Medical Association*, in its consideration of the matter, "the investigation was largely confined to the attempt to confirm or disprove by animal experimentation the reliability and success of von Ruck's methods and practices in the production of

immunity to tuberculosis. The studies were begun in Asheville at Dr. von Ruck's laboratory, but were later transferred to the Hygienic Laboratory in Washington, the reason given being that Dr. von Ruck would not concede the right of the government's representatives to conduct an independent and uncontrolled investigation and summarily-interrupted the investigation in Asheville. It would seem from the report that the von Rucks did not have sufficient confidence in their methods to be willing to be investigated unless they had supervision and control over the investigation, truly a remarkable stand for a scientist to take.

"The pursuance and completion of the investigation seems to have been much facilitated by the fact that in their publications the von Rucks have claimed an experimental basis for their system of tuberculosis therapeutics. They claim that their "vaccine" has been evolved from data derived from animal experimentation and certain serum tests, and the results of its administration are claimed to be shown also by the same methods. It has been claimed that the vaccine is stable, but as is clearly shown in the report, it is 'unstable, subject to deterioration, and is impossible of duplication with certainty.' From this it would appear, therefore, that it can not be standardized for practical purposes, since by the time the results of the protracted tests are known, deterioration may have occurred. It will be recalled in this connection that von Ruck had severely criticized the work of Dr. R. S. Cummings previously reported in *The Journal*, in which that author showed that immunity in guinea-pigs was not produced by treatment with the vaccine but that the susceptibility of the animals to tuberculosis was apparently increased as a result of the treatment with the vaccine. From the report to the Senate it would appear that this criticism was unjustified, and that the real reason for the failure of the guinea-pigs to be protected was not the failure to do certain 'serum tests' but the deterioration (now admitted by von Ruck)

of the vaccine, aside from the fact that it is questionable 'if indeed it had ever possessed the immunizing properties which Dr. von Ruck thought to have demonstrated.'

"Guinea-pigs were not immunized against injections of tubercle bacilli by the use of the vaccine in doses recommended by von Ruck and continued for the length of time, and longer, which he claimed as adequate for the purpose. On the contrary, it was found that most of the animals so treated exhibited increased susceptibility. Von Ruck insists as one of the important links in his work that the immunity of the animals shall be demonstrated by serologic methods before the final tests by inoculation, but the incorrectness of this attitude is shown in the report where the statement appears, 'This decisive test [the result of virulent inoculation], having shown that the animals were not immunized, it is a matter of indifference [to me] what degree of supposed immunity they might have shown by serological methods.' The experiments made to demonstrate that the serum of persons or animals treated with the vaccine, and said by von Ruck to possess the necessary immune antibodies to destroy the virulence of tubercle bacilli, failed to confirm that claim.

"It was not found possible to obtain direct evidence as to whether or not the vaccine would render persons in health immune to tuberculosis, but the report states that the indirect evidence on this point offered by Drs. von Ruck in proof of the success of the vaccine in producing immunity was faulty and inadequate. One of the most striking portions of the report is that which discusses the attempts made in von Ruck's laboratory by some one interested in the outcome of the experiments to alter the entries in the laboratory record book in regard to the use of controls in certain serum tests. Such an occurrence, as the report states, 'had the effect of removing the entire test from [my] consideration as a scientific proceeding,' and causes speculation as to whether the investi-

gation was not desired for reasons other than purely scientific ones."

MILITARY SURGERY IN THE PRESENT WAR.

An interesting article on the military surgery of the European war, by J. P. Hogue, New York, is published in *The Journal of the American Medical Association*, December 19, 1914. He points out that the conclusion derived from the experience of the Spanish-American and Russo-Japanese wars that the modern gunshot wounds were more humane than those from weapons formerly used hardly applies at the present time. It might have been true formerly, he says, when the number of men engaged was comparatively small and when there was little use of the modern high-powered shrapnel shells. By some of the experiences with the wounded in France, he finds it not the case now. In the month of August, it was noticed that a large number of rifle bullet wounds were clean, especially when the bones were not involved. Since then the daily life of the soldiers has been hard and the average soldier's clothing is in a bad condition and it is hard to see how a bullet traversing such clothes could stay aseptic. Shrapnel wounds are, of course, more infectious, and the infections probably occur at the time of reception of the wound. Transportation of the wounded, considering the conditions, is creditably carried out, and the dressings *en route* are practically always in good condition on the patient's arrival at the base hospital. As many of the wounded as possible were sent to the south of France, but all along the railroad, temporary hospitals have had to be started for patients who were too sick to be further transported. In the extreme north of France, hospital ships have come into use, and are well equipped, and some of them have Roentgen apparatus. Practically all the wounds seen are from rifle bullets and shrapnel. One saber wound was observed at the American ambulance, but no

bayonet wounds. Accidental injuries, such as fractures, are rare. The 30-caliber nickeled steel rifle bullet used by the Germans makes a small entrance wound and a larger exit. The course is generally straight but may be deflected by a large bone, and ricochet bullets make wounds that are sometimes ascribed to dumdum bullets. To prove the use of such a bullet, it would be necessary to find it in the wound. When a strong bone, such as the humerus or femur is struck by a bullet, within its zone of maximum speed, it is completely perforated, which is rare, or it is completely shattered. Near the center of the fracture the fragments are apt to be small, but long fissures extend up and down the shaft. When a bullet, at the end of its trajectory course, strikes a bone, a simple fracture results. Short flat bones, such as the clavicle or rib, are generally completely fractured, especially with glancing wounds, and small bones like those of the wrist or ankle are often extensively comminuted. Shrapnel bullet wounds are in general more severe than those from small arms. The shrapnel bullet travels at a low rate of speed and causes a large amount of laceration. Perforating shrapnel wounds are rare. The missiles generally lodge in the tissue and carry with them parts of clothing or equipment. These wounds vary greatly in size, and are practically always multiple, seventy-five having been counted in one soldier. Their destructive force on bones is very great, generally grinding them to fragments. The more characteristic injuries of parts are noticed. The one saber wound of the scalp was a simple wound without fracture. One case in which a rifle bullet had completely traversed the skull was seen and cases of furrow wounds of the skull were not uncommon. They were mostly from front to back, and on the side of the head, and accompanied with fracture of both inner and outer tables. Compound fractures of all parts of the skull were very frequent from shrapnel wounds. Wounds of the face and eyes by rifle bullets were not uncommon. Fractures of the in-

ferior maxilla were numerous, and in the shrapnel injuries, part of the skin or side of the face was often torn away, and some of the underlying bone gone in many cases. In the Paris hospitals, these cases were turned over to the dental surgeons, with sometimes brilliant results. In very complicated fractures with loss of bone, the plan of treatment at the Beaujon Hospital was to apply a dental wire splint immediately and dress the wound of the soft parts until infection was overcome, and operation or plastic work could be done in a clean wound. Wounds of the neck are comparatively rare. In one case, the patient seemed to be moribund but when the piece of shrapnel which showed through the external wound was removed, he began to breathe normally; the shrapnel had been pressing on the phrenic nerve. Wounds of the chest were not uncommon. Two interesting heart cases were seen. In one the bullet laid free in the pericardial sac, and it moved up and down with every beat but apparently caused the patient little inconvenience. A surprisingly large number of patients had non-penetrating wounds of the abdominal wall, many of them simply small particles of shrapnel imbedded under the skin and several cases in which they had entered and pursued their course under the skin were observed. The modern rifle bullet is not a harmless one. There is little effort, according to the field surgeons, on the part of the mucous membranes to close up perforation. Most of the patients are now being transported to the nearest base station in a sitting position, and are treated expectantly. Bullet wounds in the lower part of the abdomen anteriorly or particularly through the buttocks posteriorly are particularly fatal, on account of the perforation of the large intestine, and resulting abscess. Wounds of the perineum are comparatively rare. The most interesting surgical facts brought out have been in regard to wounds of the extremities. Practically every one of them is infected at this stage of the war. The complete fractures of the humerus and

femur are specially serious and an infected joint often occurs in a short space of time. Injuries of the humerus are more tractable than those of the femur. Amputation of the arm has rarely to be resorted to, unless there is some injury to the brachial arteries high up or a complication, like gas gangrene. The best of surgical judgment is required in the management of these long bone fractures; good and efficient drainage must be established early, and be maintained, and fragments removed. The limb must be immobilized and in case of the femur extension must be employed. A plaster hip spica has been found to be impracticable on account of its becoming loosened and the excessive discharge. These patients have been for months living under terrible strain, and with insufficient food, and the reason that conservatism can be used at all is that they are young. It is too early to speak of the most dreaded complications of gunshot injuries—tetanus and gas gangrene. A supply of anti-tetanic serum was provided for by France and it was the practice to give every soldier an immunizing dose on admission. In four hospitals in Paris, none has had over six cases. Gas gangrene is more common, especially after shrapnel wounds. Most of the French surgeons do not believe in extremely large incisions for drainage, but comparatively small ones, frequently irrigated with peroxide. Many are in favor of draining and forcing oxygen gas under pressure into the affected tissues for a considerable length of time, and at rapid intervals. The results have been good in some cases, but in many others, amputation has been necessary, and it has often failed.

A NEW DEPARTURE IN MEDICAL LICENSURE.

"The unsatisfactory results of the conventional methods for drafting laws for the regulation of the practice of medicine have been generally admitted. In many states, the introduction of bills providing for separate boards and different standards for

each new and fantastic sect or cult has become an expected feature of every session of the legislature. Yet the growth of knowledge regarding preventable diseases, and the increasing appreciation on the part of the public of the importance of state efforts for the conservation of life, are developing an appreciation of the importance of regulating equitably and permanently the licensing by the state of those who desire to treat the sick for compensation.

"As an executive and as a member of both houses of the state legislature for many years, Hon. George H. Hodges, governor of Kansas for the last two years, has had an extensive opportunity for consideration of this question. Realizing the unsatisfactory condition of the practice laws in most of the states, the governor appointed a commission to consider the entire question and to draw up and recommend for passage a bill providing a single standard for all persons desiring to treat the sick, regardless of the school of practice to which they might belong. On this commission were appointed Dr. J. A. Milligan of Garnett, formerly a member of the state senate; Dr. J. E. Sawtell of Kansas City; Prof. W. L. Burdick of Lawrence, dean of the law school of the state university; Hon. Fred D. Smith of Hutchinson, formerly speaker of the House of Representatives, and Mr. F. T. Ranson of Wichita, president of the Stock-Yards National Bank. This commission has drafted a bill providing for a preliminary examination of all persons desiring to practice medicine, surgery or any other form of healing art. The bill provides for a board of preliminary examination, made up of the chancellor of the state university, the president of the state agricultural college and the president of the state normal school, *ex-officio*, who shall examine all persons desiring to treat the sick in any way. Any persons seeking a license from the state medical board, the board of osteopathy, the board of chiropractic or any other board must first satisfy the board of preliminary examination that he has had a four years'

course in some reputable or established high school or its equivalent, and has spent at least four years or at least eight months each at some reputable professional school which includes in its course anatomy, physiology, pathology, surgery, obstetrics, chemistry, bacteriology, symptomatology, diagnosis, urinalysis, hygiene and sanitation. Suitable sections for the administration and enforcement of the act are included, together with sections amending the medical practice, osteopathic and chiropractic laws so as to make them uniform with the proposed bill.

Medical practice acts are primarily and solely for the good of the public. The report of this commission, and the bill which it has drafted," *The Journal of the American Medical Association* believes, "marks an epoch in medical legislation. It is the first distinct recognition of two important principles which must sooner or later dominate such legislation in all of our states. The first is the necessity and equity of a single standard for all persons, regardless of 'schools,' and by inference, the inequity of different standards for different schools. The second and equally important principle is that the examination and licensing of persons desiring to treat the sick for compensation is not a medical but an educational problem. The recognition of this fact in the designation of the three leading educational authorities of the state as the board of preliminary examination is a most important step in the development of better conditions in state regulation of the practice of medicine."

DO YOU WANT A STATE MEDICAL JOURNAL?

As the February number of *THE JOURNAL* goes to press but eight of the county organizations have reported the results of their annual meeting for the election of officers. It is a lamentable fact that the *JOURNAL* has not up to the present time received the kind of support that it must receive in the future if we are to continue publishing a state

journal. Outside of the papers read at the Orlando meeting of the Association their have been less than a dozen original articles sent in for publication. In more than one instance we know where papers have been read before county organizations but have not been sent in for publication. The titles suggest that the subject matter would be of interest to the profession of the state, the names of the authors leave no doubt in our minds that the papers are well worth publishing. In several instances correspondence from *THE JOURNAL* asking that articles read before County Societies be sent in for publication has failed to secure anything more than a promise to comply. *THE JOURNAL* needs and must have your moral support, Mr. Reader—it is not the other fellow but *you* upon whom *THE JOURNAL* must depend if it is to succeed.

We earnestly ask that every reader of *THE JOURNAL* contribute his share toward the making of an attractive medical journal, and we would especially ask all County Society officers to put their shoulder to the wheel.

COUNTY SOCIETY NEWS.

CALHOUN COUNTY.

The Calhoun Medical Society was organized on January 14th last and the following officers elected to serve a term of one year:

G. T. Crozier, Blountstown, President.

B. V. Elmore, Blountstown, Vice-President.

C. W. Harper, Crawfordsville, Vice-President.

E. B. Reeder, Clarksville, Treasurer.

S. S. Bridges, Blountstown, Secretary.

DUVAL COUNTY.

At the regular meeting of the Duval County Medical Society held on January 12th, Dr. Raymond C. Turck delivered an address on "The Surgery of Bones." Dr. Turck's address, accompanied by a lantern

demonstration, was most interesting and instructive.

ESCAMBIA COUNTY.

The following officers for the ensuing year were elected at the regular meeting of the Escambia County Medical Society held in Pensacola January 12th:

L. deM. Blocker, President.

William D. Nobles, Vice-President.

F. A. Brink, Secretary.

M. A. Lischkoff, Treasurer.

Geo. E. Kilpatrick was elected to the Board of Censors, the other members of the Board holding over being S. R. Kennedy and J. H. Fellows.

The application for membership of A. M.

Ames and W. D. Payne were received and referred to the Board of Censors.

At the regular meeting of the society held January 26th, Dr. D. C. Thompson presented an able paper on "The Treatment of Tuberculosis."

ST. LUCIE COUNTY.

At the regular meeting of the St. Lucie County Medical Society, held on February 6th, the following officers were elected for the ensuing year:

W. E. VanLandingham, President.

D. E. Rose, Vice-President.

B. L. Whitten, Secretary-Treasurer.

E. E. Rollins, R. C. Boothe and D. Rose, Board of Censors.

E. E. Rollins, Delegate to the State meeting.

Reviews from Current Literature

APERIOSTEAL AMPUTATION.

Lyle, Henry H. M.: *Aperiosteal Amputation*, J. A. M. A., 1914, Vol. LXIII, p. 1149.

Lyle severely condemns the periosteal method of amputation, that is, the operation in which the end of the bone is covered by a periosteal flap. Of ninety-six amputations of the thigh and leg by Cramer, but twenty-six had good stumps and but two patients could bear direct weight. Lyle states that in thirteen thigh amputations he found but one end bearing stump.

The osteoplastic and tendinoplastic methods—that is the operation in which the end of the bone is covered by a flap of bone or tendon—give splendid results in selected cases, but the aperiosteal amputation practically always produces a painless, end bearing stump, free of bony spikes and spicules and capable of early use.

In the aperiosteal method the periosteum is removed for a distance of at least one cm. above the saw line, and the medullary canal is scraped out for a like distance. The skin and muscle flaps should be planned so that the line of scar does not come directly under the end of the bone. Large nerve trunks

should be injected with one per cent solution of novocain before division.

The aperiosteal amputation is simple, universally applicable and when properly done should never fail to provide a useful stump.

R. C. T.

POTT'S PARALYSIS.

Davidson, A. J.: *Pott's Paralysis; Restoration by Albee's Operation*. N. Y. Med. Jour., 1914, Vol. C, p. 125.

The writer reports the cure of two cases of Pott's paraplegia by transplantation of a strong bone graft from the tibia to the bisected spinous processes in the diseased area.

Paralysis of the lower extremities in tuberculosis of the spine is generally ascribed to compression of the cord, through some active process, such as destruction of the vertebral bodies with consequent angulation of the spine, abscess pressure between bone and dura, new granulation tissue pressing upon or penetrating the dura, etc.

In a large majority of cases of Pott's paraplegia, except where there is actual sclerosis or other disease of the cord itself,

the symptoms may be relieved by fixation of the spine in hyperextension. This not only relieves pressure on the cord, but induces healing of the tubercular bony lesion. Recumbency with traction in extension, affords most complete rest and fixation, but is often difficult to accomplish and always necessitates long confinement with its manifold disadvantages and dangers.

The Albee operation is designed to produce an ankylosis of the vertebral spines, thus forming a strong bony splint posteriorly which in a reasonably short time obviates the necessity for mechanical or external fixation.

Davidson states that he has had gratifying results with the method in a number of cases of spinal tuberculosis without paralysis, as well as in the two reported cases of paraplegia. He believes that failures with the method, which have been reported, could have been avoided had the operators used a graft long enough to secure firm anchorage above and below the diseased area, or had external fixation been continued until the graft had become thoroughly sound. In none of his cases were less than five vertebræ immobilized with the autogenous graft, and external fixation was continued for at least one year after operation. R. C. T.

DISEASES OF THE BONES AND JOINTS.

Keller, Henry: *Diagnostic Aids in Diseases of the Bones and Joints*. N. Y. Med. Jour., 1914, Vol. C, p. 458.

Keller directs attention to the numerous bone, muscle or joint lesions which are overlooked while patients are treated for other diseases, and to the many cases of arthritis which are treated symptomatically with no effort to find the etiologic bacteria or their primary focus.

He quotes Milne's conclusion that all cases of chronic arthritis are due to some infective agent, and that the reason for the great variety of types is the difference in the virulency of the infective agent and the length of time that the joint is exposed to it. The termination of the arthritis, in resolution, in chronic

synovitis, in degeneration or destruction or hyperplasia of cartilage, in metaplastic bone changes, in bony ankylosis, etc., depends upon the severity of the infection.

Keller states that twenty-five per cent of cases of Pott's disease admitted to hospitals were treated by physicians for other diseases, and that the true condition was recognized by them only after kyphosis was apparent.

The writer states "that in order to make a proper diagnosis in disease of bones and joints, it is necessary to ransack every accessible part of the body in order to locate the cause of the infection; tonsils, teeth, and gums should be thoroughly inspected, the urine and feces should be analyzed carefully, and the organs of generation should be thoroughly examined. After we have found germs which look suspicious, we should do our utmost to ascertain by scientific means whether or not this germ is the sole cause of the trouble or a contributing factor only."

In addition to careful physical examination, examinations of secretions and excretion, radiography, etc., Keller lays great stress on the necessity for and the importance of the Wassermann test for syphilis, and, particularly, the complement fixation or deviation test for gonorrhœa in chronic arthritis. In view of recent studies it seems probable that more than fifty per cent of cases of arthritis deformans are caused by gonococcic infection. R. C. T.

ACUTE EPIDIDYMITIS.

Smith, D. C., and Frayser, B. H.: *Operative Treatment of Acute Epididymitis*. *Annals of Surgery*, 1914, Vol. LX, p. 719.

The writers review three hundred cases of epididymitis treated in Ancon hospital, Canal Zone, since 1908, in which operative treatment gave most gratifying results.

The writers state that the cases treated non-operatively are usually disabled for from two to three weeks, with more or less constant suffering, while the operated cases are usually free of pain on the fourth day and are up and about the wards and porches at that

time. The temperature never lasts over thirty-six hours after operation and often falls to normal in less time. The leucocyte count falls rapidly; in one case from 33,000 to 8,400 in forty-eight hours. The majority of operative cases return to duty on the sixth day.

The operation recommended by the writer is as follows:

"After shaving the parts thoroughly we use a 3 per cent alcoholic solution of iodine. External and parallel with the epididymis, make an incision into the tunica vaginalis. This incision should be large enough to deliver the testicle. Examine the epididymis and make multiple punctures with a blunt probe in the portion which is inflamed. Gently massage the part, wash with warm salt solution and return testicle to scrotum. Close the tunica with catgut and insert a narrow iodoform gauze drain. The external wound is closed with silkworm gut, using the subcuticular stitch—the drain passing out at the lower angle.

After operation we apply a sterile gauze dressing and a suspensory bandage is used to support the scrotum. On the second day the wound is inspected and the iodoform drain is removed. Daily dressings are not necessary."

R. C. T.

REPAIR AFTER FRACTURE.

Kauffer, H. J.: *A New Method of Hastening Repair After Fracture*. N. Y. Med. Jour., 1914, Vol. C, p. 1013.

Kauffer suggests the injection of fresh granulated bone incorporated with petrolatum into and between fractured bone ends to hasten repair in fractures and to act as a focus for osteogenesis in cases of delayed union.

The granulated bone-petrolatum mixture is sterilized and injected at various angles so as to infiltrate the entire mass of tissue lying between the bone ends.

The method has proved efficacious in a limited number of animal experiments. Should actual practice demonstrate that the

procedure produces bone in case of fibrous or delayed union, its simplicity should make it available for general use in certain types of cases. One great advantage is that bone grafts are introduced without converting a simple into a compound fracture.

Theoretically, the method seems practical and worthy of trial.

R. C. T.

ASIATIC CHOLERA.

Prasek: *Subcutaneous Infusion of 5 per cent Sodium-Chloride Solution as Therapy in Cholera Asiatica*. M. m. W., 1915, No. 50.

From the literature it was known to the author that the concentrated condition of the blood in cholera was not relieved by physiologic salt solution but required a hypertonic solution. In 40 cases, many of them severe and apparently beyond hope, the 5 per cent sodium-chloride solution injected subcutaneously reduced a former high mortality to 18-20 per cent.

One pint of warm sterile solution was injected as early as possible and repeated in six hours. A third injection was necessary after 12-18 hours in some cases. Soon after the first injection could be noticed a better facial expression and less cyanosis. The pulse became better and the intestinal cramping soon lost its intensity or stopped altogether. Usually on the third day the diarrhea had ceased and the stool was formed and of good color. Patients soon became thirsty and consumed large quantities of water with good results.

By mistake a number of these patients received only a 1 per cent solution. No results were achieved until the mistake had been rectified. This occurrence strengthened the contention for a concentrated solution.

Three cases among the hospital help were given the treatment immediately after an early diagnosis was made. The response was astonishing. The patients recovered in several days without having developed any alarming symptoms.

Besides the 5 per cent sodium-chloride injections all patients received tincture of

iodine 3 drops in 3 tablespoonfuls of water 4-5 times a day. This usually checked the terrible vomiting. Injections of caffeine were also used. A hot full bath soon after the pulse showed improvement was very beneficial to all patients.

T. T.

EXTRAPERITONEAL CESAREAN SECTION.

Gellhorn, George: Three Cases of Extraperitoneal Cesarean Section. *Journal of the A. M. A.*, 1915, Vol. LXIV, p. 196.

Gellhorn states that his technic has been slightly modified from that described by Kroenig and originated by Veit and Fromme. As employed in the three cases reported it is as follows: With the patient in the extreme Trendelenburg position the incision is made in the median line from the symphysis to within $1\frac{1}{2}$ inches of the umbilicus. The lower uterine segment presents. The peritoneum, which in pregnancy is only loosely attached to the lower uterine segment, is lifted by tissue forceps at its highest point corresponding to the abdominal incision. It is then transversely incised for the distance of two inches. The lower peritoneal flap and the bladder are pushed down gently until the firm connection between the cervix and bladder is reached. A denuded oval with a long diameter of about 5 inches thus results on the anterior surface of the uterus. The cut edges of the parietal peritoneum are then sewed to the edges of this denuded oval by a continuous suture. The rest of the operation is thus rendered entirely extraperitoneal. The lower uterine segment is then incised for through the entire length of the denudation. The child's head is then rotated into the incision and gently delivered, using forceps if necessary to obtain a purchase on the head. After closing the uterine incision the continuous suture is removed and the cut edges of the peritoneum repaired as they were originally.

With the sole exception of placenta previa Gellhorn considers this technic far superior to the old methods. It should not be used

in placenta previa for obvious reasons. Its advantages in other cases are: small abdominal scar with less chance of hernia; post-operative adhesions practically can not occur; less hemorrhage; escape of blood, amniotic fluid or meconium into the abdominal cavity is prevented; the post-operative course is much better.

In spite of the advantages of this method it has received but scant recognition in this country, but eighteen cases, in addition to Gellhorn's, having been reported. Growing familiarity with the technic will no doubt bring it into use more frequently. G. R. H.

THE ATROPIN TREATMENT OF DYSMENORRHOEA.

Novak, Emil: The Atropin Treatment of Dysmenorrhœa. *Journal of the A. M. A.*, 1915, Vol. LXVI, p. 120.

The use of atropin in the treatment of spasmodic dysmenorrhœa is based on the fact that atropin diminishes the irritability of the autonomic nerve endings in the uterus. Drenkhahn first reported the use of this drug in such cases in 1910 and the method was developed by J. Novak of Vienna. Novak reported 38 cases in which he had favorable results in thirty. He administered the atropin by mouth in pills of 0.5 mg. each; three pills being given each day beginning a few days before the period was expected. Failures he attributes to insufficient dosage. Stolper, who has used the method with considerable success in a large number of cases, lays stress upon a study of blood pressure. He states that when the blood pressure is high there is apt to be less response to the atropin and less likelihood of relief. The blood-pressure must be taken during the intra-menstrual period.

The author has used the method as outlined by J. Novak with encouraging results in over thirty cases. He finds that the cases which respond most favorably are those in which the atropin is pushed to the point of tolerance. The dosage differs, of course, with the individual patients. Ordinarily

about 1/100 grain is given three times a day unless some pain appears. In this event, unless there are symptoms of atropin saturation, the dose may be given somewhat more frequently. If patients complain of atropin symptoms it may be necessary to lessen the dose somewhat.

This treatment is, of course, applicable only to cases of "essential dysmenorrhœa," *i. e.*, dysmenorrhœa which is not caused by any pathological lesion of the pelvic organs. Also it gives best results in those cases with sharp, cramp-like pains. The less characteristic symptoms which so often accompany the cramps, namely the backache, headache, general lassitude, and dull bearing down pains are not greatly influenced by the atropin.

G. R. H.

INSTITUTIONAL TREATMENT OF INFANTS.

Chapin, Henry Dwight: Are Institutions for Infants Necessary? *Journal A. M. A.*, 1915, Vol. LXIV, p. 1.

The unusual susceptibility of the infant to its immediate environment and its great need of individual care furnish the basis for discussion of the best means of relieving sick infants and caring for abandoned and foundling babies. If an infant for any cause must be sent to a hospital its stay in the hospital must be as short as possible. For after the subsidence of acute symptoms most hospital babies show a progressive loss of weight which bears an inverse ratio to the age, being especially marked in children under six months. The marked susceptibility of infants to infections of all kind, especially ward infections, is a factor of vital importance in determining the stay of an infant in a institution where there are other babies. Hospital babies show a poor resistance to every added infection and it is generally the infants who have been longest in the hospital who succumb to cross infections.

Large wards and large institutions should not be encouraged and when infants need hospital care it should be in small units. There should be one good nurse to every

three or four patients and infants suffering from chronic indigestion and marasmus should not become hospital inmates. The plan of collecting foundlings in one institution should be abandoned, as it not only predisposes to high mortality and an aggravation of conditions it is supposed to prevent, but the surviving infants are rarely strong and healthy. All dangers of institutional treatment and care grow less as the child grows older. In hospitals and children's homes it is rare that an infant receives the individual attention that is necessary. As a substitute for foundling homes the author advocates the boarding out of infants in the homes of foster mothers who have received the training that would qualify them for this undertaking.

Such infants should remain under the care and observation of trained physicians and visiting nurses. Old methods will no longer be tolerated and "cottages must take the place of barracks."

J. D. L.

MEASLES.

Herrman, Charles: Measles: Incubation, Infectivity, Immunity, Early Manifestations. *Archives of Pediatrics*, 1914, Vol. XXXI, p. 885.

The infectivity of measles is greatest from twenty-four hours before to twenty-four hours after the appearance of the exanthem. According to the author's experience measles is contagious for only three or four days, which period corresponds to that ushered in by catarrhal symptoms and terminated by the fall of temperature. When the eruption is complete the disease is probably no longer contagious.

The secretions of the nose and throat, in coughing and sneezing, are the carriers of the infectious material. Desquamated skin plays no part in the contagiousness of measles. Probably from two to three per cent of all individuals possess an immunity to the disease. Infants under five months are practically immune. This applies to both artificially-fed and breast-fed babies, showing that the immunity is conveyed

through placental circulation and not through breast milk.

The author believes that second attacks are exceedingly rare and that the so-called second attacks are due to a confusion with German measles or other morbilliform eruptions. Unless there is a record of Koplik spots in both attacks an error in diagnosis is assumed. The author directs attention to the presence of Koplik spots on the conjunctiva, as well as the buccal mucous membrane, and to the swollen and injected caruncle at the inner canthus of the eye.

J. D. L.

TREATMENT OF CHRONIC LEG ULCERS.

Sonnenschein, Harry D.: The Treatment of Chronic Leg Ulcers. N. Y. Medical Journal, Vol. C, p. 1219.

Sonnenschein in a short article makes a report of a very successful method of treating chronic leg ulcers, the report is based on the treatment of three cases; the writer used a baking oven by means of electric heating of hot air, raising the temperature in the oven to 250-300 degrees, the treatments were from twenty to thirty minutes, given three times a week, the ulcers were cleaned with peroxide of hydrogen and dressed with scarlet red ointment. J. L. K-S.

SALVARSAN IN THE TREATMENT OF SYPHILIS.

Nelson, Kent, and Haines, Edgar F.: Observations of the Result of Seven Months' Experience with Salvarsan in the Treatment of Syphilis. Journal of the A. M. A., Vol. LXIII, p. 2277.

Nelson and Haines made a very instructive report of their experience with neosalvarsan in the March number, 1914, of the *Journal A. M. A.* This report was based on the treatment of a number of patients at the army hospital at Fort Leavenworth, with the usual intensive method of treatment with neosalvarsan and mercury the writers found that the percentages of negative Wassermans was only 33.3 per cent. In this report the writers give their conclusions obtained from treating seventy-five

syphilitics with Salvarsan and mercury as follows:

1. Four injections of salvarsan combined with intensive mercurial treatment have given nearly twice as many negative serum reactions as did five injections of neosalvarsan with mercurial treatment.

2. The best authorities state that with our present method of treating syphilis we can not expect to obtain over 70 to 80 per cent of negative Wasserman reactions. Salvarsan has given us 64 per cent of negative serum reaction, whereas neosalvarsan gave 33.3 per cent in nine months.

3. The drug should be used that will bring about the best result in the shortest possible time. We believe that our work with neosalvarsan and salvarsan will clearly demonstrate that salvarsan is the drug.

4. A greater number of reactions should not follow the use of salvarsan.

5. The complement fixation test is of the greatest value in diagnosis, or as an indicator to the results of treatment.

6. We believe that the results reported in this paper are of such a character as not to warrant the further use of neosalvarsan in the military service; and to all others who desire to give their patients the best possible results in the shortest possible time.

J. L. K-S.

THE WASSERMAN TEST.

Craig, C. F.: The Results and Interpretations of the Wasserman Test. The American Journal of Medical Sciences, Vol. CXLIX, 1915, p. 41.

The statistical portion of Craig's article is based on the results of over eighteen thousand tests which he has personally performed. He claims that the Wasserman test is the most valuable aid which we possess in the diagnosis of syphilis, and it is also of value as a control of the efficiency of treatment. A positive Wasserman means syphilis and the presence of living spirochaetes in the system. Even a weak Wasserman, if a provocative Wasserman, means syphilis. He states that reports from inex-

perienced workers has done great harm and made many practitioners skeptical regarding the accuracy of the test. The test should be made by trained serologists.

Great variations occur in the element in the blood which gives the reaction and certain organic and inorganic substances affect the results. The test is essentially a quantitative one and requires accurate and careful titration of reagents, and should "never be made by one not thoroughly acquainted with all the factors so far discovered that influence the results."

In regard to the technique he stated that any of the well recognized methods if performed by a thoroughly trained serologist give as good results as any other method. The original Wasserman is not superior to other methods and complete fixations are obtained as often by one method as by another.

The test is specific for syphilis except in yaws, relapsing fever, leprosy and the febrile stage of certain malarial infections gives a positive Wasserman. A positive Wasserman in other nonsyphilitic cases is due to poor technique and to misinterpretation. Eleven positive reactions were obtained out of 2,643 supposed nonsyphilitic patients, in four of which malaria was diagnosed and blood tested in the febrile stage. These became negative when the fever had subsided. Three were diagnosed tuberculosis; one diagnosis was questionable and in three a diagnosis of pityriasis rosea was made. In the latter the reaction was fifty per cent inhibition and in two of the cases a history of syphilis was later obtained and these got well under antisyphilitic treatment.

The percentage of positive reactions in various stages show, the highest in the secondary, then primary, tertiary, latent, congenital and para-syphilitic, in the order given. More than one test must be made. If only one test is made ten per cent of negative results will result in primary cases, four per cent in secondary cases, thirteen

per cent in tertiary cases and thirty-three per cent in latent cases. In secondary syphilis 100 per cent will give positive if the test is repeated. About eighty per cent show the reaction in the fifth week and thirty-four per cent in the first week.

The factors influencing result of tests are variations in amount of complement fixations in the blood. The serum of a syphilitic may give a negative at certain intervals although previous and subsequent tests show positive reactions. A paper on this subject was published in the *Journal of the American Medical Association* in 1914, Vol. LXII, page 1232, under the heading, "Variation in the Strength of the Wasserman Reaction in Untreated Syphilitic Infections." Results on prisoners at the military prison have shown variations from day to day and with different amounts of serum. Reaction will vary from positive to negative in a short period of time demonstrating the utter uselessness of a single negative in eliminating syphilis and also explains the discrepancies in reports from different laboratories.

Alcohol will produce a negative reaction. 180 to 240 c.c. of whiskey, or 90 c.c. of 95 per cent alcohol, or 700 c.c. of Munich beer will render a strong positive reaction negative and may last as long as three days. The reaction disappears a few hours after the administration of alcohol.

Bacteria in the blood may give a positive (streptococci and staphylococci). Two strains of aureus tested give a positive reaction. This shows the necessity for collecting blood under aseptic precautions.

The amount of blood tested should never be less than 0.02 c.c. 0.1 c.c. serum gives the best results. The maximum amount of serum should be used. The cerebrospinal fluid may be negative when the blood is positive. However, the negative results in cerebrospinal fluid depends entirely on the amount of fluid used in the test and if the maximum amount allowable with the particular method in use be tested a positive

result will be obtained in 100 per cent of cases of cerebrospinal syphilis even when small quantities give ten per cent of positives.

The test can not be relied upon to differentiate between paresis and cerebrospinal syphilis. Paresis will give 100 per cent positive in blood and cerebrospinal fluid. In tabes sixty to seventy per cent will be positive with blood while a maximum test of spinal fluid used will give nearly 100 per cent positive. If 0.08 c.c. of spinal fluid is used only five to ten per cent will be positive. However, all three give atypical results and Wasserman can not be depended upon to differentiate between paresis, cerebrospinal syphilis and tabes.

The Wasserman test is of great value as test of efficiency of treatment and has proven the superiority of salvarsan over mercury but has shown that even salvarsan fails to cure. Relapses can be diagnosed long before clinical symptoms appear and first symptom of relapse is a positive Wasserman. The Provocative Wasserman, described by Gennerich, in the *Berl. klin. Wochenschr.*, September 19, 1910, No. 38, is of great value in checking up a cure. It gives a positive where the Wasserman remains negative. Twenty-five per cent inhibition or less can not be taken to mean a syphilitic infection. Craig gives the following rules in regard to the interpretation of the Wasserman test:

"1. If the diseases other than syphilis, that have occasionally been found to give a positive reaction with the Wasserman test, can be excluded, a double-plus reaction (absolute inhibition of hemolysis) is diagnostic of syphilis. Under such conditions I consider the reaction as absolutely specific, whether symptoms are present or not, and whether there is or is not a history of infection.

"2. Under the same conditions a plus reaction (one in which there is at least 50 per cent of hemolysis) may, in primary, tertiary,

and latent infections, be interpreted as diagnostic, provided there is a clear history of infection or clinical symptoms present. In the absence of either history or suspicious symptoms a plus reaction should never be considered as diagnostic.

"3. A diagnosis of syphilis should never be made upon a plus-minus reaction (one in which there is less than 50 per cent of hemolysis). Many normal individuals give such a reaction, and it is of no value whatever as a diagnostic sign of syphilis, and of very little value as a guide to treatment.

"4. A single negative reaction is of no value in excluding syphilis. That this is true is clearly demonstrated in the titrations of the blood serum of syphilitic patients already mentioned, where even the most severe secondary cases occasionally gave a negative reaction. Only when a negative reaction is repeatedly obtained, over a period of at least a year, can it be considered as good evidence of the disappearance of the disease, and in all such cases the result of the test upon the cerebrospinal fluid, a luetin test, and a provocative Wasserman test should be made if one desires to be sure of the absence of syphilis. This may appear to be a very radical stand regarding the value of a negative Wasserman test, but my experience has shown that only by applying all of the tests mentioned can we be sure that a patient is really free from infection."

H. H.

THE PHYSICIAN AND THE DRUG HABIT.—The patent medicines have much to answer for. It is not the amount of the habit-forming drug that creates the demand for its use habitually but it is its regular repetition even in small quantities. Many unsuspecting ones have become slaves to cocaine from the use of the widely advertised catarrhal powders which are on the shelves of every drug store in the land. One of the much advertised cures for consumption has made many slaves to the morphine habit.—Chas. W. Fisk, M. D., in *The Journal of the Oklahoma State Medical Society*.

NEW AND NONOFFICIAL REMEDIES.

Since publication of New and Nonofficial Remedies, 1914, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies":

ARBUTIN, MERCK.—This brand of Arbutin has been accepted for inclusion with New and Nonofficial Remedies. Merck and Co., New York.

Antiseptic Supply Co.:

Cupric Applicators; Cupric Applicators, Special; Caustic Applicators, Special; Stypstick Applicators, Special (accepted for the appendix to N. N. R.).

ANTIRABIC VACCINE.—Consisting of eighteen doses, one dose is sent by mail daily. Pasteur Institute of St. Louis, St. Louis, Mo.

BACILLUS COLI COMMUNIS VACCINE.—Marketed in boxes of 6 ampoules. E. R. Squibb and Sons, New York City.

CONCENTRATED DIPHOTHERITIC ANTITOXIN.—Marketed in syringe packages containing from 500 to 7,500 units. F. Stearns and Co., Detroit, Mich.

CLINICAL EVIDENCE.—In view of the unsatisfactory evidence for the therapeutic value of articles proposed for inclusion with New and Nonofficial Remedies, the Council adopted the following statement:

"Claims are often made, however, which are incompatible with common experience and sometimes defy the laws of nature. Claims which seem highly improbable will not be admitted by the Council unless the manufacturer supports them by evidence acceptable to the Council. In doubtful cases the Council acts on these questions under the advice, and with the co-operation, of its staff of clinical consultants."

CHANGE OF FORMULA.—In view of information received from the Antiseptic Supply Company the Council has modified

the description of Cupricsticks to indicate that these are tipped with a mixture of copper sulphate, alum and potassium nitrate, containing 20-25 per cent of copper sulphate.

CUPRIC APPLICATORS (Copper Sulphate 20-25 per cent).—Wooden sticks 6½ inches long tipped with a mixture of copper sulphate, alum and potassium nitrate, containing 20 to 25 per cent copper sulphate. Antiseptic Supply Co., New York (*Jour. A. M. A.*, Dec. 26, 1914, p. 2290).

DIPHOTHERIA ANTITOXIN.—Marketed in packages of 10,000 units ready for use. Memorial Institute for Infectious Diseases, Chicago.

FRIABLE TABLETS OF EMETINE HYDROCHLORIDE, MULFORD.—Each tablet contains emetine hydrochloride 0.032 gm. H. K. Mulford Co., Philadelphia, Pa.

H. K. Mulford Co.:

Solution Pituitary Extract.

Laboratory of W. T. McDougall:

Pasteur Antirabic Vaccine.

PYOCYANEUS VACCINE.—Marketed in boxes of 6 ampoules. E. R. Squibb and Sons, New York City.

PITUITARY LIQUID.—Armour and Company have informed the Council that its Pituitary Liquid is adjusted to uniform strength by the method of G. B. Roth (*Jour. of Pharm. and Exper. Thera.*, July, 1914). The description of Pituitary Liquid, Armour, has been revised to indicate this.

PASTEUR ANTIRABIC VACCINE.—The virus is prepared according to the method of the Hygienic Laboratory, Washington, D. C. A dose is sent by mail each day. Twenty-one to twenty-five doses constitute a treatment. Laboratory of W. T. McDougall, Kansas City, Kansas.

RADIUM BROMIDE.—The market supply is a mixture of radium bromide and barium bromide and is sold on the basis of its radium content. It is sold for use in applicators, inhalatoriums and injection solutions. Radium bromide is marketed as:

RADIUM BROMIDE, RADIUM COMPANY OF AMERICA.—All deliveries are made subject to the test of the U. S. Bureau of Standards or any reputable expert designated by the purchaser. The Radium Company of America, Sellersville, Pa.

RADIUM BROMIDE, STANDARD CHEMICAL Co.—Sold by the Radium Chemical Co., Pittsburg, Pa. (*Jour. A. M. A.*, Dec. 26, 1914, p. 2289.)

RADIUM CARBONATE.—The market supply is usually a mixture of radium carbonate and barium carbonate and is sold on the basis of its radium content. It is sold for use in applicators. Radium carbonate is marketed as:

RADIUM CARBONATE, STANDARD CHEMICAL Co.—Sold by the Radium Chemical Co., Pittsburg, Pa. (*Jour. A. M. A.*, Dec. 26, 1914, p. 2289.)

Radium Company of America:

Radium Bromide, Radium Chloride, Radium Sulphate.

RADIUM CHLORIDE, RADIUM Co. OF AMERICA.—This form of radium chloride has been accepted for inclusion with New and Nonofficial Remedies. Radium Co. of America, Sellersville, Pa.

RADIUM SULPHATE, RADIUM Co. OF AMERICA.—This form of radium sulphate has been accepted for inclusion with New and Nonofficial Remedies. Radium Co. of America, Sellersville, Pa. (*Jour. A. M. A.*, Dec. 26, 1914, p. 2290.)

Standard Chemical Company:

Radium Carbonate.

STAPHYLO-ACNE VACCINE.—Marketed in boxes of 6 ampoules. E. R. Squibb and Sons, New York City. (*Jour. A. M.*, Nov. 14, 1914, p. 1763.)

STREPTOCOCCUS VACCINE.—Marketed in boxes of 6 ampoules. E. R. Squibb and Sons, New York City.

SLEE'S NORMAL HORSE SERUM.—Marketed in vials containing 100 c.c. Abbott Alkaloidal Company, Chicago.

SOLUTION PITUITARY EXTRACT.—A solution of a purified extract of the posterior

lobe of the pituitary gland of the ox. It is assayed so that 1 c.c. represents 0.2 gm. fresh gland. It is used by hypodermic or intramuscular injection mainly to stimulate the uterus contraction in labor. It is supplied in the form of ampoules containing 1 c.c. Solution Pituitary Extract. The H. K. Mulford Co., Philadelphia, Pa. (*Jour. A. M. A.*, Dec. 5, 1914, p. 2043.)

TYPHOID VACCINE, IMMUNIZING.—Marketed in packages of three syringes and in packages of three ampoules. H. M. Alexander and Co., Marietta, Pa. (*Jour. A. M. A.*, Nov. 28, 1914, p. 1953.)

TYPHO-SEROBACTERIN, MULFORD, IMMUNIZING.—Each package contains 3 syringes of Typho-Serobacterin graduated as follows: First dose, 1,000 million killed sensitized typhoid bacilli; second dose, 2,000 million killed sensitized typhoid bacilli; third dose, 2,000 million killed sensitized typhoid bacilli. H. K. Mulford Co., Philadelphia, Pa. (*Jour. A. M. A.*, Oct. 19, 1914, p. 1296.)

TYPHOID BACILLUS VACCINE.—Marketed in packages of six syringes, each containing 1,000 million bacteria; also in packages of six syringes containing, respectively, 100, 200, 400, 600, 800 and 1,000 million bacteria. Greeley Laboratories, Inc., Boston. (*Jour. A. M. A.*, Oct. 31, 1914, p. 1577.)

BENZENE, MERCK, H. P. CRYSTALLIZABLE.—A brand of medicinal benzene. Merck and Co., New York. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

BENZENE, MEDICINAL.—A liquid consisting almost entirely of benzene, C_6H_6 . Medicinal benzene has been used in the treatment of leukemia. In many cases the improvement is such as to suggest an apparent cure. A large number, if not all, cases relapse or succumb to the toxic action of the benzene. The drug is in the experimental stage and should be used with caution. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

CANTHARIDIN.—The anhydride of cantharidic acid preparations of cantharidin are used in place of corresponding preparations

of cantharides and have the advantage of being cleanly, and more uniform in strength. A 0.1 per cent solution of cantharidin in a fixed oil raises blisters when kept in contact with the skin. (*Jour. A. M. A.*, Jan. 2, 1915, p. 53.)

DIGITOXIN, MERCK.—A brand of digitoxin admitted to New and Nonofficial Remedies. Merck and Co., New York. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

GLYCOTAURO CAPSULES (half size).—Each capsule contains Glycotauro (see N. N. R.) 0.15 gm. Hynson, Westcott and Co., Baltimore, Md. (*Jour. A. M. A.*, Jan. 23, 1915, p. 343.)

LUETIN.—An extract of the killed cultures of several strains of the *Treponema pallidum*, the causative agent of syphilis. It is employed for the diagnosis of syphilis. It is of use in the examination of tertiary cases, but rarely gives a positive reaction in primary cases or in untreated secondary cases. Luetin is supplied as:

LUETIN, MULFORD.—Packages sufficient for a single test, for five tests and for fifty tests. The H. K. Mulford Co., Philadelphia. (*Jour. A. M. A.*, Jan. 23, 1915, p. 343.)

LEUCOCYTE EXTRACT.—An extract of leucocytes obtained from exudates produced in the pleural cavity of rabbits or other animals. It is said to be of value as an aid to specific serums or antitoxins and vaccines. It is claimed to be of use itself where the nature of an infection is not known. Its use

is in the experimental state. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

LEUCOCYTE EXTRACT, SQUIBB.—A leucocyte extract prepared according to the method of Hiss. It is sold in syringes containing 10 c. c. E. R. Squibb and Sons, New York City. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

SILVER CITRATE, MERCK.—A brand of silver citrate admitted to New and Nonofficial Remedies. Merck and Co., New York. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

SILVER LACTATE, MERCK.—A brand of silver lactate admitted to New and Nonofficial Remedies. Merck and Co., New York. (*Jour. A. M. A.*, Jan. 2, 1915, p. 54.)

THE CONSERVATION OF CHILD LIFE.—One of the greatest handicaps a child can have is an abnormal mother. We are all familiar with the various types; the timid and inexperienced mother who calls us up on the telephone once or twice daily for advice on the most trivial matters; the vacillating mother who listens to her neighbors and is ready to try some new food every day if advised to do so, no matter how irresponsible her advisers may be; the conceited mother who having read some work on the care and feeding of babies, thinks she knows it all; and so on ad lib. Some of these women, with patience on the part of the physician, may be educated and taught self-control; others may be intimidated or browbeaten into submission; others fortunately, the smallest number, are hopeless, and the sooner they leave one, as they are pretty sure to do, the better for our peace of mind. Their unfortunate offspring, unless by a special dispensation of a kind Providence, are doomed to an early athreptic death or to a neurotic existence.—Martin J. Synnott, A. M., M. D., in Pediatrics.

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THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, March, 1915

Number 9

ORIGINAL ARTICLES

GENERAL SANITARY MANAGEMENT.*

JOSEPH Y. PORTER, M. D.,
State Health Officer,
Jacksonville, Fla.

Before engaging with you in a most pleasant occupation, that of discussing general sanitation with all its kindred subjects, I am reminded of a command given me years ago by my old negro mammy, "Not to forget my manners."§

I wish, therefore, to thank you for the very courteous invitation which you have extended to me to be present this evening and join in your discussions; but I am seriously impressed with the fact, however, that your generosity has gotten the better of your good judgment, for I am conscious of my inability as a public speaker to hold interest and not tire, when dealing with questions so vital, especially as I see before me such a gathering of culture and intelligence.

I never was a public speaker. My inclinations from early youth led me in a contrary

*An address delivered, by invitation, before the State Federation of Women's Clubs, at Lakeland, Fla., November 18, 1914.

§The speaker paused to say, "God bless the memory of that old black face. The recollection of the devoted love and untiring care of my 'Mammy' are tender memories of my childhood, as I know they must be to every Southern born man or woman of the older generations. The young of today will never know the affection and devotion of these old nurses; nurses who not only cared for us in health but watched nightly by our bedsides when we were sick, who contributed with stories to our amusement and shielded us from deserved punishment. Yes, I say again, God bless their memories. I am thankful that it was vouchsafed to me, after I was given children of my own, to see my mammy laid tenderly away, when her life's work was done.

"Pardon my digression but I never lose an opportunity to pay tribute of love to those guardians of health and happiness of our early youth."

direction—desk work—and even when as a school boy I was forced on each Saturday to declaim from the rostrum of the school-room, I invariably became muddled, and Grampian Hills, and father's flocks, and feeding them, became so mixed that I was often forced to sit down in confusion. However I shall try to do my best to entertain you, and hope that when I have finished, you may not be so greatly disappointed or regret having extended to me an invitation to engage with you in these pleasant exercises.

The subject of general sanitation and conservation of health is such a vast one and covers so large a field that it is impossible to do more in a general talk than to touch the high places here and there, and leave to a reading public to fill in the intervening spaces from writings on the subject.

Each week, as you doubtless remember, an article inspired by the executive office of the State Board of Health on some topic relating to the public health, appears in the press of the State, and those of you who have followed closely, fully recognize the versatility of the subjects discussed and which connected directly or indirectly with public health instruction, are presented to the public in an interestingly plain manner, divested of all technical phrases.

The keynote of sanitation is cleanliness. Let it be remembered that cleanliness is the trunk of the tree of healthful living and those things that conduce thereto are the branches which spring from this trunk, and with their foliage shelter the public against disease and disease agencies, which produce sickness, increase the cost of living, destroy happiness and shorten life.

All governments spring from a unit. The unit of government in the early ages was

the family; from the family came tribes; from tribes a general or central management of social and political affairs. So is it in the conduct and management of health matters. Individual responsibility must be understood, appreciated, and accepted—else there can not be any concert of action in health betterment or efficient results. It can be understood, therefore, that without co-operation on the part of individuals and a willingness to comply with advice coming from a central health authority, little if any good can be effected in ameliorating conditions which will lessen or suppress disease and lengthen the life of the human. I do not believe that too much stress can be laid upon this point—individual responsibility; what is everybody's business is no one's affair or concern. Let each and every one look out for his sanitary defects—not those of his neighbors. Each family must see to its own hygiene, individual and civic. It would be a very easy matter, then, if each individual recognizing the responsibility resting upon him or her, as such to care for the family in a manner that disease would not get in its work, to have a wholesome and utopian state of affairs in any community; and it is here that the women's clubs can do most effective work.

Individual responsibility is most clearly seen in dealing with the preventable diseases. Sickness can be avoided by adopting measures which science and experience has taught to be effective, and largely rests with the individual citizen. For instance, we know that smallpox can be escaped by attending to proper vaccination. This admits of no argument because the proofs are daily witnessed by intelligent observers, and those who without prejudice care to examine and search the literature on the subject, must be convinced, and furthermore, as seen in living examples of physicians and nurses, who, protected by vaccination, mingle daily and hourly with the sick with smallpox. So too in typhoid fever. The statistics furnished us by the United States Army Department show con-

clusively to any fair-minded person that the use of the antityphoid bacterin will prevent the occurrence of typhoid fever in those persons of susceptible age. Let me read the table as given by the Army Medical Department:

Annual average		Cases.	Deaths.
prior to			
1909	.....	536	37
1910	.....	232	16
1911	.....	80	11
1912	.....	26	3
1913	.....	3	0

In 1913 only three cases of typhoid occurred in the entire enrollment of more than 90,000 men. Of these three cases, two were in new recruits who developed the disease, four and five days, respectively, after they enlisted. Only *one* case occurred in an inoculated soldier.

Anti-typhoid vaccination was begun in the Army in 1910, but was optional throughout that year. In 1911 it was optional until March when it was made compulsory. In 1912 it was compulsory throughout the entire year, and has been since that time.

Malaria can be escaped by screening against the mosquito. Porches should be screened, because when sitting on the porch in the evening the infected mosquito has ample time to bite and convey the parasite of malaria before the victim retires for the night. Then, if the house is not screened, there should be a net over the bed to protect the sleeper from danger during the hours of rest. Possible breeding places should also be destroyed.

Diphtheria can be suppressed and cured by diphtheria antitoxin; rabies by the Pasteur vaccine, and so on, I may mention hookworm, influenza, and many more in the list of preventable disorders which due care on the part of the individual can either prevent, cure or shorten in length of sickness. Of course, there is no denying the fact that "sickness walketh oftentimes in the noonday as well as in the darkness of night,"

and no one knows when he may be exposed, but of the list of disorders which are classed as preventable there are none that can not be shortened in duration of sickness and probably cured, if the individual accepts and follows advice which is so freely given in lay press as well as in professional journals for the care and prevention of such diseases.

There are two diseases, however, for which the public have no excuse, except that of indifference, to offer for contracting. And those two are smallpox and typhoid fever. The preventives are simple and within the reach of every person. In Florida the Jenner vaccine is distributed free for the asking, and typhoid bacterin is given likewise to the indigent. It would be well if it were given without cost as in the Jenner vaccine. I have, therefore, no patience with a maudlin sentiment for individual rights, by those who oppose vaccination for smallpox, and by those who neglect to protect themselves against typhoid because of the cost, when the same individuals will pay twice over to see a popular play at a theatre or in entertaining friends at a cabaret cafe. It would seem that the economic side of the problem of health preservation against those two diseases would appeal to the thinking public. A case of typhoid is estimated to cost about \$500.00, but this estimate is more often below than above the average, counting loss of time, physician and nurse bills, drugs, etc. Then again, about every one in ten cases of typhoid fever dies. A human life according to the best statisticians is valued at about \$5,000.00. See then what a loss to a community a single case of this disease will occasion—a needless and useless sacrifice of life, and waste of money. It is the individual taken singly who is responsible for his own sickness from a preventable disease, and the municipality having the responsibility of a communal nature which is responsible for allowing obstinacy and prejudice to oppose and negative measures which will prevent, to the detriment of law-abiding and intelligent citizens, who will

always co-operate. The objectors, opposers and controversialists to health measures and disease preventive methods are as much a menace to any community as is the communicable disease itself.

The following table gives an approximate statement of mortality of some of the preventable diseases occurring in the United States during the past year, including our own State:

DEATHS FROM PREVENTABLE DISEASE IN THE UNITED STATES IN 1912.

	Registration area 63% of total population of U. S. Bureau of Census.	Estimated for whole U. S. on basis of population.	Estimated for Florida on basis of population.
Tuberculosis	90,360	143,429	1,129.
Dysentery, Diarrhea, Enteritis	53,391	84,747	667.
Pneumonia	51,495	81,738	644.
Broncho-Pneumonia	28,422	45,114	355.
Diphtheria and Croup...	11,013	17,481	138.
Typhoid	9,987	15,852	135.
Whooping Cough	5,619	8,919	70.
Measles	4,240	6,730	53.
Scarlet Fever	4,038	6,409	50.
Malaria	1,848	2,917	23.
Tetanus	1,303	2,068	16.
Smallpox	163	262	2.
Hookworms and other Intes. Parasites	127	201	1.6
Rabies	74	117	1.
Unclassified	6,461	10,255	81.
Totals	268,543	425,879	3,355.6

The census figures for the registration area of the United States cover a population of a little more than 60,000,000. Florida's population is approximately 750,000 (taken from National Census of 1910), about 1/80 of that of the registration area. Hence, the proportionate figures for this State are arrived at by a division of the totals for the registration area by 80. These figures are undoubtedly too low with reference to some of our more common diseases, such as typhoid, hookworm, malaria, and rabies; while they may possibly be a little high for

others, such as pneumonia, broncho-pneumonia, and tetanus.

There is one of the preventable diseases that I must not neglect to mention, for in fact it is one of the most important of all the ills that destroys life and makes untold misery to sufferers and their loved ones. I mean tuberculosis, and that form of tuberculosis which is known as consumption, pulmonary tuberculosis.

In the registration area last year there were 90,360 deaths from this disease, as you will see from the above table, and this is 63% of the total population, as before stated, of the entire United States, according to the Bureau of the Census, and the estimate of approximately 150,000 deaths is obtained by working out the proportionate number of deaths per 100% population.

GENERAL SANITARY MANAGEMENT.

This brings the number of deaths from tuberculosis for Florida to 1,129, a too conservative estimate, in my opinion.

All of the estimates are probably a little low by reason of the fact that the census figures from the registration area are from the states that are most actively engaged in public health work. Consequently the deaths from preventable disease in these states are probably *below the average* for the entire country. However, I believe these figures will give approximately the number of deaths from preventable disease, as nearly as they can be estimated.

I am not gifted with mind reading, but I think if I could read the thoughts of some of my listeners I would find that they would like to ask what about the tuberculosis sanitarium which was authorized to be built in 1909, and here comes in a bit of interesting history in regard to this movement; let me tell it to you.

In 1909 on my recommendation and earnest solicitation the legislature passed an act providing for the construction of a sanitarium in the State of Florida for the indigent tuberculous of the State, those

affected with pulmonary consumption, and authorizing the Board to make rules and regulations, and to accept donations of land and other gifts (for the government of this institution). Before the legislature that enacted this law had adjourned, another bill was prepared and passed, at the request of the Governor and Comptroller, diverting \$60,000.00 of the State Board of Health funds to the pension fund of the State to make up for a shortage in that fund for the payment of pensions to Confederate Veterans.

I have always contended that the State Board of Health should have a reserve fund for emergencies, and that fund should not be less than \$100,000.00. Without a reserve fund of some size the efficient work at Pensacola in 1905 could never have been accomplished. As the State Board of Health handles no money at all, and only receives funds for the payment of debts after the debts are contracted, the State Health Officer nor the Board could not, in any way, therefore, misuse this fund as it is at all times under the direct control and disposition of the Comptroller and Treasurer, whatever its amount and size, so it seems to me, that as a matter of good policy, and sound business judgment and forethought, the Board should have sufficient funds on hand at all times to meet any emergency of epidemic prevalent or other sanitary requirement, that might arise, that service could be paid for promptly, and thus economically, because it is a more economical measure to pay cash than to pay by note. Accordingly, by strict economy of administration, I had built up a reserve of nearly \$100,000.00, which unfortunately attracted the attention of the legislature. Prior, however, to the passage of this bill, and having had in mind for some years the necessity for sanitary care and supervision of the indigent consumptive of the State, I have looked about for a suitable location to establish an outdoor

sanitary institution, and by outdoor I mean treatment in tent houses, so that invalids from this disease could have the open air treatment, both by day and night, and at a less cost than in stone, wood, or brick establishments. Dr. Ennis of Narcoossee, in Osceola county, an octogenarian philanthropist, who for a number of years maintained a small, it could hardly be called a sanitarium, probably the best word would be "home," for a few of the "downs and outs" of this disease that came to Florida and applied to him for assistance, offered to the Board as a gift for this purpose his ground space and the buildings that he had already erected; but on looking over the location it was found the doctor did not have land enough such as would be needful for the proper establishment of an institution for races and sexes; and additional land could not be, at that time, obtained. This was the start that was made in the direction of a State Tuberculosis Sanitarium. Then came the passage of the bill authorizing the Board to construct a sanitarium, but before any further effort could be made, the reserve fund of the Board was depleted by diverting more than half to the pension fund.

Since that time there has been a reversal of opinion by medical men in regard to institutional treatment for consumptives. For several years I have thought that the home treatment of the disease could be made more effective than by institutional management, if proper instructions were given to the family, both as regards the care of the patient and the care of themselves, in adopting measures to prevent the spread of the disease from the sick to the well, and with this advantage, that the invalid would be surrounded by loved ones, would have comforts that could not be obtained (and I am speaking now for the indigent) in institutions conducted on a charity basis, and thus escape that terrible feeling of homesickness which, those who have

been taken away from home to sanatoria, invariably complain of so bitterly.

The proceedings of the Anti-Tuberculosis Association of recent years have had much to say upon home visitation, and I wish to quote quite freely from the Association proceedings, and especially of 1913, what Dr. Herman Biggs has to say on the subject, for no more eminent authority in the United States in health work generally, and in tuberculosis work, can be listened to:

"Among the new methods created by the anti-tuberculosis work, none has been productive of more good than home visitation, for only in this way has the real problem been brought to light. As we look back, we realize how helpless we were without this simple but very powerful means of attacking disease. Home visitation aims to bring to light other cases of the disease in the same family; it strives, if possible, to trace the cause or source of the infection; it seeks to learn what influence the patient's environment has on his disease, and on the health of others in the home; it attempts to devise means of curing the infections which have already occurred and of preventing further infections. It tries, by an intensive study of many cases, to gather experience to guide in the care of all. In short, home visitation constitutes the absolutely necessary and only means of learning the conditions surrounding and the causes of the infection. In this connection we may quote from an editorial in a recent number of the New York Medical Journal: "* * * Home visitation undoubtedly supplies the surest way to reach the indifferent and ignorant portion of the public, and everyone familiar with public health administration knows that this constitutes the great obstacle in the successful prevention of disease. These people cannot be reached through public lectures or through printed circulars of information, or yet through exhibitions; such methods are all far too indirect, too impersonal. But visit

the people in their homes, show them that your interest is personal, help them with their individual problems, teach them the wherefore—and the solution of many a difficult health problem lies close at hand. This has been well shown by the success attending the work carried on against tuberculosis and by the splendid results obtained in New York in recent years through the campaign against infant mortality.

It is evident, from what has been said, that the only effective means of reaching a very large part of the population will be closed to the public health administration if home visitation is interfered with, and it is equally clear that there can be *no home visitation without notification of and registration of cases* by the health authorities.

From the close-range study of tuberculosis, we have learned the absolute necessity for individualizing the treatment of each case in order to obtain satisfactory results. Hardly any two cases are exactly alike or amenable to the same method of treatment. The factors which enter into the social pathology of various cases are numerous and the solution of the problem presented requires intelligence of the highest order. For this reason, in New York special courses have been arranged for the training of nurses in social service work, and the Department of Health has availed itself of the aid afforded by numerous social workers and various organizations to secure instruction for its corps of visiting nurses. Much of this work is in process of development, as highly efficient social service nurses are still but few in number.' "

I do not wish to tire you with quotations, but the evidence of others supporting my own contention is so strong that I cannot resist doing so.

Dr. Brenner in "One Year's Results at the Home Hospital" in the same Journal of Transactions, speaks of the same subject by saying:

"There is no way of estimating how many other cases are directly traceable to the careless habits of consumptives. Tuberculosis is a social evil, and to get results we must treat not alone the patient *but also his family*.

Finally the consumptive becomes a bed-ridden, far advanced case, and the fruits of his carelessness are visited upon the heads of innocent ones. What these people really need is proper hygienic housing, good food, and constant medical supervision. In this respect the *home hospital* is unique in furnishing the first adequate, practical control of this most important group. Not only is the patient cared for, but he is taught how to live so as not to infect the other members of his household. The children are given every hygienic advantage, and the parents firmly impressed that it is morally wrong to bring more children into the world. This eugenic idea has been liberally discussed, and it is most gratifying to see how readily the parents grasp the situation. Large families of the poor result not from volition but from ignorance.

In a similar degree the sanatorium is *inadequate*. Aside from the *great expense of sending patients away for treatment and maintaining the family at home*, it is a great hardship for both the sick and well members to be separated. Those remaining at home, although subjected to the danger of infection before the patient was removed, are without medical supervision and advice. If the infection has had time to spread before the removal of the patient, the disease usually gets a firm foothold before its ravages become noticeable. Separation also acts as a deterrent in the treatment of the tuberculous member, especially if temporary dependency is threatened or there is any doubt about the comfort of those from whom he has been removed. He still feels the burden of responsibility and consequently worries. To take a patient suddenly

from a life of rest in ideal surroundings such as the average sanatorium provides, and send him back to one of toil, in the inimical environment in which he has contracted the disease, is another *weakness* in the *sanatorium* method of treatment. Such a practice is too often fraught with disaster to all members of the family. The disease frequently recurs, and consequently well members of the family are endangered. Comparatively few patients are willing or able to leave family and friends for a sufficient time to be cured."

Again, Dr. Charles S. Prest, says:

"Education, legislation, and money are the forces with which to fight tuberculosis in the country and small towns as well as in the cities. Whatever program is employed in the solution of this problem, be it competent diagnosticians, visiting nurses, education, legislation, exhibitions, adequate relief, or a combination of all these, with many others, it must be comprehensive enough to take into account every resident, regardless of how far removed he may be from congested community life."

If a sanatorium,—a building in which cases are housed—what then? This is the question that is causing us the most acute concern in the field of tuberculosis. We exercise infinite pains in inducing our patients to enter the institution; we wait patiently for their discharge, in the hope that they will come forth improved, or with the disease arrested; we watch them for a short time after they return, only to discover that much of the work that we have done has been wasted and that a relapse seems almost inevitable. The facts are no longer a matter of guesswork or conjecture. They are proved in a most pathetic manner by an investigation into the discharged cases of one large sanatorium in this country. In the summer of 1912 three organizations jointed together to conduct this investigation: The Montefiore Home,

The United Hebrew Charities, and the Free Synagogue of New York.

In this investigation we limited ourselves to the patients discharged in 1909, 1910, and 1911—459 in all. Every case was followed up, and both the medical and social aspects of each case were thoroughly covered by an expert. I quote from a report written by the Chairman of the Committee, Mr. Fred M. Stein:

"Taking the cases year by year, we found the proportions of those who could not be located, but with reference to whom some information could be obtained through relatives and clinics, and of those who could be definitely located to be as follows:

Year	Discharged	Not Located	Not located but information secured	Located
1909	109	57 per cent	19 per cent	24 per cent
1910	191	53 per cent	17 per cent	30 per cent
1911	159	39 per cent	13 per cent	48 per cent

Analysis of cases of those with respect to whom we had complete medical and social histories disclosed that:

Of the 26 discharged in 1909—	5 were worse, 16 were stationary, 5 were better.
Of the 53 discharged in 1910—	24 were worse, 24 were stationary, 5 were better.
Of the 70 discharged in 1911—	36 were worse, 31 were stationary, 3 were better.

"Of the 1911 cases where it was possible to locate 48% and to obtain information from relatives and clinics with regard to about 13% further analysis of the statistics discloses the following:

			49 cases discharged arrested stage			17 cases discharged improved			4 cases discharged unimproved		
Cases Located	Worse	Stationary	Worse	Stationary	Better	Worse	Better				
70	22	27	11	4	2	3	1				

from which it appears that of the cases located, 52% had grown worse at the time of the investigation, which was from six months to a year after discharge from the institution.

"It would seem to suggest, therefore, that the sanatoria, as they are now administered, turning patients out into the world partially restored to health and without taking any further interest in their welfare or their disease-spreading potentialities, are not a very efficient instrument. The question, therefore, arises whether there is not some practical method for supplementing the institutional treatment, which represents an investment of many millions of dollars in such manner as to make it more efficient both economically and socially."

"This critical investigation means without question, that 52% of the work done in Bedford Sanatorium—that \$52.00 out of every \$100.00 spent in treating the patient in the institution—is wasted in less than a year's time. If such a leakage were to occur in any business house owned or managed by a member of the Board of Trustees of any charitable agency, an army of efficiency engineers and scientific managers would at once be assigned to the problem." (Rabbi Sidney E. Goldstein.)

Dr. E. F. Campbell of Ohio says: "I wish to state that, in my opinion, the Ohio State Sanatorium is not now a factor of any consequence in the campaign against the disease in Ohio. I have no particular criticism of the internal management of this sanatorium. It is an elegant plant, costing the State of Ohio approximately \$725,000.00 but with only a capacity of 140 patients. The average daily attendance in 1913 was 108. There are fully 35,000 cases of this disease in Ohio, with approximately 7,000 deaths annually, and yet this institution is not filled to its capacity. If the institution were full all the time, it would still be a small factor in the fight."

Now I do not wish to be understood as depreciating, in any manner, the assistance or the worth of institutional treatment for those who are financially able to live in comfort and in luxury. Institutional treatment for them means a great deal in education, in regularity of living, in discipline of the physical to the professional therapeutic training; but even then, there are no State institutions in this country that are large enough to take in all even the well-to-do class, and those that are not gathered under such protection and segregation become the means of distributing the disease. Public sanatoria for consumptives is another matter entirely from private institutions of this character, for they involve a pecuniary cost to the State in institutional treatment for the indigent; that is to say, the poor, who are not financially able to properly care for themselves at home. I doubt, very much, whether, and the statistics on the subject bear me out—that the efforts which the older States in health work have put forth, have met with the success that was hoped for or expected.

The substitute for institutional treatment which I propose to you shall take the place of sanatoria, in the care of indigent consumptives is the home hospital plan by the district visiting nurse. I do not exactly like the term "visiting nurse," for it does not adequately express the idea; "Instructor," is the better word, because when going into a territory she very properly makes a survey of the situation as to disease and sanitary conditions, and teaches the best methods of prevention. It is now recognized by most people in any community that this "nurse" can do little toward effecting a cure of the individual case until certain changes in the sanitary conditions of one type or another are brought about. She can, however, minister to the comfort of the individual patient. The Instructor is a powerful factor of education in the

families where tuberculosis and other diseases prevail. Experience has been that the visiting nurses have been able to find many cases of tuberculosis and other diseases in the smaller communities of the State which were not known to the health or other social agencies of those communities. They have been able to gain access to many homes which have not been reached in any other way.

A state traveling "nurse" should also be attached to the public exhibit, which we hope to have later on. The travelling visiting nurse will visit all, or as many as possible of the schools in the towns where the exhibit is located, giving lectures on hygiene. Visit workshops and factories, giving similar talks, make a sanitary survey of the town, if possible, and inform the women's clubs and other social and philanthropic organizations of her findings and make suggestions as to the improvement of conditions as they are found to exist. She will also act as demonstrator at the exhibit during certain periods, giving instructions in infant hygiene to mothers, bedmaking for outdoor sleeping and the like.

As every fresh advance from point to point has been made in combating tuberculosis, from hospital accommodation for advanced cases to sanatoria for early cases, to outdoor life and suitable occupation for incipients, to open air schools and preventoria for delicate predisposed children, with every fresh point taken, the need of close personal individual care and supervision is demonstrated. In nursing and management, in manual service and teaching, admonition based on the latest work of science, personal care becomes obviously the indispensable organ of executive control. Even large collective control asserted in a broad and far-reaching way, through social legislation as it may be enacted in the future, will never be possible except as administered, and wielded by individuals. At the starting point of every possible

avenue of danger of infection or breaking down of human strength there will always be the home, the family, its surroundings to be watched and guarded. Every possible method of tuberculosis control comes back finally to this foundation and center of control. The nurse has been trained for this service. No other agent has as yet been found so useful as she in exerting this intimate control.

Twenty years ago there were not more than twenty graduate nurses at work in the homes of the people. It is only eight or nine years since the first nurse was appointed distinctly for the care of the tuberculosis, one whose sole and single task was to look up the patients who were "lost" from a large dispensary. (The John Hopkins of Baltimore.)

Today there are nearly 3,000 nurses, almost all of whom are engaged indirectly in this campaign, and about 500 who are working exclusively for tuberculosis associations.

A distinguished member of your organization has asked me to say something to you this evening on vital statistics.

To the general run of the public, and to those who have not studied the subject, statistics of almost any description seem to be merely a vague conception of the compilation of figures, and for vital statistics, the notation of a number of births and deaths, in a given place within a certain given period. The real study of the subject, however, goes further than that and brings out not only the number of deaths in mortuary statistics but the cause of deaths, which may be attributed to occupational industries and climatic conditions.

The collection of vital statistics becomes thus a method of bookkeeping of life and death, with an analysis of the debit and credit side of living.

The question has often been asked: "Does it pay a citizen to expend the taxpayer's money in gathering together these

statistics?" I would like to say parenthetically right here, that in order to be of any value, vital statistics must be correctly stated, and that the Census Bureau will only accept such statistics as can be assured of being ninety per cent of accuracy.

An important feature of vital statistics, that is to say the credit side of the ledger, is that it, by accurate reporting of births, would legalize the birth of every child and thus furnish the citizen with legal proof of citizenship.

On the debit side of the ledger, the loss side, it can be said to prevent to a far greater extent than a superficial consideration of the subject would seem to indicate, certain crimes; and taken together both in credit and debit, it places the progressive communities of this country in line with those of enlightened European nations, who have long ago recognized the tremendous importance and are rapidly enforcing the accurate collection of such statistics.

You need not be reminded, because I expect that you have already considered the fact, that even of our own people, those that are proudest of their name and lineage, there are many who cannot prove their decent more than two generations, while it is said the peasants of Europe can trace theirs for hundreds of years, so that aside from the aesthetic value of vital statistics collection, it gives to every citizen a far reaching material value. We, of the State Board of Health, know that questions of inheritance are continually arising from the requests that we have for authentic copies of reports of birth and deaths, which involve the settlement of estates which depend upon legal proof of decent. Questions of age with reference to occupation, life insurance, etc., oftentimes make a certificate of great value, and in case of sudden death a birth certificate might be the only means of giving a child honorable identity.

In his book on "Civics and Health," Prof. Wm. H. Allen, aptly says in speaking of vitality tests and vital statistics:

"Two things will disclose the strength or weakness of a bank, and the soundness or unsoundness of a nation's banking policy, namely, a financial crisis or an expert audit. A searching audit that analyzes each debit and each credit frequently shows that a bank is solvent only because it is not asked to pay its debts. It continues to do business so long as no obvious weaknesses appear, analogous to measles, adenoids, or paralysis. A frequent disorder of banking results from doing too big a business on too little capital, in making too many loans for the amount of cash held already to pay depositors upon demand. This disorder always comes to light in a crisis—too late. It can be discovered if looked for in advance of a crisis. Many individuals and communities are likewise physically solvent only because their physical resources are not put to the test. Whether individuals or communities are trying to do too much business for their health capital, whether the health reserves will pay debts that arise in a crisis, whether we are ill or well prepared to stand a run on our vitality, can be learned only by carefully analyzing our health reserves. Health debits are compared with health credits for individuals by vitality tests, for communities by vital statistics."

And later on, in his admirable work, that: "Vital statistics of greatest consequence are not the number of deaths or the number of births, not even the number of deaths from preventable diseases, but rather the number of cases of sickness from transmissible diseases. The cost and danger to society from preventable diseases, such as typhoid, diphtheria, scarlet fever, measles, are imperfectly represented by the number of deaths."

And still further on, in his work, which will be found interesting reading to those who care to delve into such a subject, Professor Allen says: "The greatest service of vital statistics is the educational influence. Health administration cannot rise far above the hygienic standards of those who provide the means for administering sanitary law. The tax paying public must believe in the economy, utility, and necessity of efficient health administration. Power and funds come from town councils and state legislatures. To convince and move these keepers of the purse, trustworthy vital statistics are indispensable. Information will be used for the benefit of all as soon as it is possessed by all.

"The facts we want, are, for the most part, common, everyday facts, easily recognizable even by laymen; for example, births, deaths, age at death, causes of death, cases of transmissible diseases, conditions found upon examination of children applying for work certificates, etc. Where expert skill is required, as at state and national headquarters, it can be found. Every layman can train himself to use skillfully the seven pillars: desire to know, unit of inquiry, count, comparison, percentages, classification, and summary."

Later on in this meeting I shall ask the privilege of introducing the statistician of the State Board of Health, who will give you some figures in regard to the half year's work of the Board in its endeavor to obtain accurate statements of birth and deaths, as occurring in cities of 2,000 and over, in the State of Florida.

Quite recently a tabulated account of this work has been sent out to those who might be interested, and your Federation is always included in the distribution of all literature from the State Board of Health, which gave the figures as reported to the State Board of Health for the past six months.

There is a law on the statute books of the State, enacted in 1899, which enjoins

every physician in the State, those who are at the head of state institutions, and all midwives, to report to the State Board of Health every birth and death occurring in the State.

At first we tried to obtain this information through the doctors, and method after method was devised to have the request of as little labor to the practicing physician as possible, and at the same time to furnish the Board with the desired information. Addressed postal cards with a form printed on the reverse were distributed to every doctor in the State, but the returns received were so meager and desultory that, discouraged and disheartened, the effort was allowed to pass into innocuous desuetude, until this past year when another attempt has been made to collect the vital statistics of the State, not through the physicians but through the municipalities, or towns of 2,000 and over, by asking the council or governing municipal body to select some one who would do this work, who would be afterwards appointed by the State Board of Health, and who, in the cities not in the registration area of the Census Bureau, would receive tangible compensation for their services. This compensation has been, for the present, fixed at 25 cents for each original certificate of birth sent to the State Board of Health, for towns not already within the registration area, and 6 cents for abstracts in the towns of the State which had been accepted by the Census Bureau as being on the list of registration cities of the United States. These fees are paid only when the returns are 90 per cent accurate.

While this system at the present time promises fair returns in those cities and towns which, impressed with the importance of vital statistics, are endeavoring to carry out the method described and required in the "Model Ordinance" proposed by the U. S. Government for this purpose, yet there are smaller communities which

are indifferent to the subject and do nothing in this respect. If we are to have state-wide registration of vital statistics, and have Florida admitted by the Census Bureau in the registration area of States, the legislature must heal the defects in the present law by amendments, so as to adopt for the State the Model Ordinance. If the people of the State have sufficient interest in the subject, if they can be brought to appreciate the value of the work to the State, if your Federation will actively campaign for the purpose, I believe our forthcoming legislature will comply with recommendations of the Board and reconstruct the present statute on progressive lines.

Mr. Voorhees will tell you just how we arrive at the supposed 90 per cent accuracy in returns, because very naturally the question will be asked, how do we know we are obtaining accurate returns, and that is a very proper question, and one that should be given due consideration and reply.

In conclusion, I wish with your permission, to explain some of the policies of the State Board of Health, which seem to have been rather harshly and unnecessarily criticised by your Federation. I understand that there has been quite recently a circular letter addressed to "Mr. Voter," in which the State Board of Health has been censured for not erecting a tuberculosis sanitarium; for not constructing a plant for the manufacturing of hog cholera serum; for not erecting a hospital for the indigent crippled children of the State, which it is claimed the statutes of the State provided for; and lastly, that the State Health Officer has failed in his promise to incorporate the system of district visiting nurses for instruction against the spread of pulmonary consumption.

Perhaps it would be better that I should give you a little more history, side-lights that you have never seen, because I do not believe that you have thoroughly understood conditions as they have arisen, and

the insurmountable obstacles which have presented themselves to the State Health Officer, principally in a depleted and likewise restricted treasury.

In 1889 at the special session of the legislature called by Governor Fleming in February of that year, the State Board of Health was organized in conformity with the constitution. Although the present constitution was adopted shortly after the convention of 1885, the legislature had, up to 1889, failed to enact laws that would carry into effect articles of the constitution which provided for a State Board of Health and in the following language:

ARTICLE XXV.

"SEC. 1. The legislature shall establish a State Board of Health and also county boards of health in all counties where it may be necessary.

"SEC. 2. The State Board of Health shall have supervision of all matters relating to public health, with such duties, powers, and responsibilities as may be prescribed by law.

"SEC. 3. The county boards of health shall have such powers and be under the supervision of the State Board to such extent as the legislature may prescribe."

At the special session in 1889 \$50,000.00 was appropriated to carry into effect as much as was necessary in incorporating the new system, with a provision that not more than one-half mill should be collected in each year from the accessible property of the State, for the support and maintenance of the State Board of Health. I take it you are acquainted with the State law, which was enacted by the special session of 1889, so I will not read it now. Suffice it to say, however, that the framers of that law seemed to have had in mind, if one will read it carefully, a quarantine provision against yellow fever, smallpox, and cholera. Incidentally, here and there, through the Act something was casually said about sanitation and the duties of the State Health Officer in looking after the same, throughout the State, but the main gist of the law was to protect the State against a further invasion of yellow fever, the cause of which, at that time, was not

definitely known, and the true nature of the disease, its etiology, etc., was not acquired until a commission from the United States government, in the latter part of 1898 and the beginning of 1900, through human demonstration, proved conclusively that the old idea of an invisible gas, miasma, or such agency, was groundless, and therefore abandoned.

The funds which the State Board of Health received from the State treasury are all given in the transactions of the Board in its annual report each year, from the date of its organization to the present time, and not until within four or five years have the funds of the Board been of such proportion that its income called for any comment from the general public. During the administration of Governor Mitchell, who succeeded Governor Fleming, under the authority given by the constitution to the Governor, in the apportionment of levy of taxation there was no tax collected for the State Board of Health, and in a subsequent year the tax levied was cut in half, to one quarter of a mill, so that during the administration of Governor Bloxham in 1899, in an epidemic of yellow fever prevailing in both Miami and Key West, together with outbreaks of smallpox throughout the State, the Board found itself bankrupt; so much so, that in the campaign against yellow fever in Miami, and the isolation of that town from the rest of the State, completely preventing the spread of the disease, even to the suburbs of Miami, funds were given mainly by the late Henry M. Flagler to carry on this work, and altogether for the construction of a hospital and the care of the indigent sick of yellow fever, of which there were a number of cases in Miami that year.

In 1901 the legislature, on my insistent and urgent recommendation, transferred the management and control of the State maritime quarantine, that deals with shipping and commerce principally from foreign

ports, from State control to that of the Federal Government of the United States, the Public Health and Marine Hospital Service. Arrangements were made in this transfer of property and authority, by which these stations were taken over by the Government and paid for at an appraised value, the sale being effected through the instrumentality of Governor Jennings, then Governor of the State, and the Board of State Institutions.

At the same time the State was given supervisory and advisory control of quarantine by appointing the State Health Officer in a quasi official capacity in the Marine Hospital Service.

Some \$50,000.00 was realized from the sale of these stations. The larger proportion of this sum was originally expended from the State Board of Health treasury in erecting the stations and conducting them, this money coming from the tax levied for the use of the Board. \$20,000.00 was received for the Pensacola quarantine station, which derived its income, not from the city of Pensacola, nor from the State of Florida, for that matter, but from foreign shipping, principally, arriving at the port, which was large during the early years of the State Board of Health administration. The income of this local board, the Escambia County Board of Health, through the shipping, discharging of ballasting, etc., defrayed all expenses of the Escambia County Board of Health, embracing every improvement in the way of construction of buildings, salaries of employees, etc., and as has been remarked, at no time was a pecuniary charge on the city of Pensacola or the county of Escambia. But, and I wish that you would bear this point in mind, the same legislature which transferred this station to the control of the U. S. Government, also enacted a statute that the sum received from the sale of this one station should be transferred to the city of Pensacola (some \$20,000.00), which was accordingly done, when the Government paid for the same.

The balance of the money accruing from the sale of the other stations which should have been returned to the State Board of Health treasury, was placed in the general revenue of the State, by direction of the Governor or the Board of State Institutions, I am not certain which. Thus you see that the Board has never been "flush," so to speak, with funds to do all that was desired, or might be required of it, by those who are capably inclined to criticize.

In regard to hog cholera serum, after a consultation with the Comptroller of the State, it was decided that it was cheaper and advisable to procure this serum from large factories operating for commercial purposes, than to construct a building and provide necessary equipment for its manufacture. I took into consideration what the cost of such a plant would be, and estimating the value of money which would be expended in construction of such a plant at 6%, I found that the Board could, at that time, I do not say since, but at that time, save money by purchasing, rather than in its own manufacture. In its own manufacture not only buildings would have to be constructed, but a number of additional employees engaged, animals bought, etc., all of which would vastly increase the cost of production.

I have thought for several years that this proposition was not really one belonging to the State Board of Health, which is mainly charged by the Constitution with the care of the health of the human, and incidentally preventing diseases that are transmissible from the lower animals to the human. Hog cholera can not be classed with the latter, for it is a disease of the lower animal, not transmissible to man, and in the treatment and prevention of this trouble among swine the commercial aspect is one that preponderates, and as such should be considered by the producers and not be made a charge upon the general tax-paying public. It can be said to be class legislation. Moreover, it has been pointed out that there is as much equity in providing the citrus growers of the State

with a preventive, if one is known, of the citrus canker, and the boll weevil to agriculturalists, as it is to provide a serum to the farmers to increase the value of their swine herds.

In the bill of the indigent crippled children, which was a pet measure of Governor Gilchrist, there is also connected a little bit of history that is interesting. Governor Gilchrist had prepared this bill and had it introduced in the Legislature of 1911. The judiciary committee of the Senate had rejected it and when I happened in the Governor's office, unexpectedly one morning, he was in deep distress over the failure of his pet measure, and asked me if I would not assist him in trying to convince some of the legislators of the merit of the proposition. Reading over the bill, I saw where it could be amended with a proviso that would meet the objections, and took it to the chairman of the Public Health Committee of the Senate, who was the Senator from my county, Monroe, and asked him if he would not call his committee together, again present it to the judiciary committee, and have them change their opinion. This he did, with the proviso that until the number of crippled children of the State were so increased, that the State Board of Health would deem it advisable to make it necessary for proper treatment, to construct a building, that the State Health Officer was authorized to engage with any local institutions for their care, and this has been done. This bill without the proviso would never have been passed. The white children are treated at St. Luke's Hospital under the excellent and admirable care of Dr. Raymond C. Turck, who gives his services gratuitously; and so too, at Brewster, the colored children are under the same supervision. Sixty-nine children have been treated at a cost to the State of \$5,036.28.

I believe that I have answered the criticisms that have been made concerning the work of the Board and I regret that no effort was made to ascertain the facts in

each instance prior to making public an arraignment of the officers of the Board in certain directions.

You will remember that about a year ago an article appeared in the press of the State which called attention to the fact that women are the natural sanitarians in our civilization? As this is your meeting—I will not say, “ladies” federation, but “women,” because I believe the term “woman” is the highest tribute of admiration, praise and appreciation that can be applied by us men to your sex. Why should it be said “every inch a man” in speaking of the greatness and brains and mental capacity of the man who has achieved distinction, and not say, the fullness and breadth, devotion and fidelity to duty of a woman, all of which, and much more, characterizes a true woman—therefore, when I say that this is particularly a woman’s day and woman’s meeting, I am speaking in the highest praise, and attaching to the world all that goes to make most sacred to a man the name of his mother. If the mother or the wife is careless or ignorant, we poor men have but a slim chance, from the time of birth to the end of the spanking period. The doctors and health boards may indicate what is necessary, and they may have laws enacted to regulate matters of hygiene and sanitation, but the women are after all the executive officers to make these laws effective, because most of the things that affect the bodily welfare of the race touch us in the home, and there it is the woman is supreme. For health is largely a matter of education, woman is the teacher, and home the school. Therefore, I repeat again, that it is largely upon the efforts of you women that the coming generations shall be so instructed that they will appreciate, and not only appreciate but accept and carry into effect, the teachings which you before them have accepted, and which I trust you are daily endeavoring to exercise. Hence the woman in the home must incorporate into her education what science has to teach in health matters. She

may have intuition, this has been boasted of from the time of Mother Eve, that women are superior over men in this particular—and this would seem to be an extremely serviceable possession, too, when something else is not mistaken for it. We grant the lower animals an instinct, but intuition in a woman is a high mental characteristic, and I would not for one moment put it parallel to that of the lower animals, because, in the woman, it is ruled in a great measure by a higher attribute—that of reason. Therefore the mother’s influence in the home should be for cleanliness, physical as well as mental and moral, for her husband as well as for her children. From the time that the children can accept any teaching which will have an impression upon the mind, she should instill the importance of purity and of cleanliness, and I might say—and pass on to the father likewise as an example for his own children—cleanliness all the way from the finger nails and teeth to the soul. The woman as a teacher has an influence second only to that of the mother in the home. She should realize that the most important duty to the younger children in her charge is in the care of their bodies and of their health. They all have inquiring minds, active and alert to acquire knowledge almost as they breathe the air, and her chief concern for their mental advance is to see that they do not absorb wrong ideas. Physical cleanliness is the road to mental health and to moral wholesomeness.

You will pardon me for this digression from subject to speak of the influence of women in matters of sanitation, but it seems to me an opportune time to express my deep appreciation to you as allies and promoters in better physical and moral uplift, and of the value to health which the Federation of Women’s Clubs is giving health organizations everywhere, and which is particularly noticeable in the stimulus to civic cleanliness and civic morality in our own Florida. I am exceedingly pleased, therefore, to have

this opportunity to pay my tribute to the value and worth of your organization in the State.

TOXÆMIAS OF PREGNANCY.*

FREDERICK J. WAAS, M. D.,
Jacksonville, Fla.

In recent years our conception of the toxæmias of pregnancy has assumed an entirely new aspect. We are now beginning to realize that all the symptoms incident to gestation are secondary to some substance or substances circulating in the maternal blood stream, which have their origin in the products of conception; that is from the fetus or placenta, or perhaps from the rapidly growing uterus. The severity of the symptoms depend upon the quantity of the substances thrown into the circulation, and on the ability of the mother to react to the substances. Heretofore all our investigations were directed to the changes found in the kidneys, liver and even the brain, and the symptom-complex was attributed to the alteration of function in these organs. The pathological changes found in the various organs in patients who succumb to one of the toxæmias of pregnancy are at present considered secondary to the effects produced by the foreign substances circulating in the blood. The nature and exact origin of these substances is as yet not definitely known. The preponderance of clinical investigation, however, points to the fact that these symptoms of intoxication are due to a protein substance found in the blood stream of the pregnant woman and never found in the non-pregnant state. The whole range of the toxæmias of pregnancy and especially eclampsia, should be viewed from the point of view of the maternal circulation overcharged with foreign protein substances. In eclampsia we have many clinical manifestations pointing to this. The sudden onset of symptoms and their sudden

disappearance, the sudden changes found in the urine and their sudden disappearance, the greater frequency of toxæmias in primiparas and the fact that eclampsia is more frequent in twin pregnancies, tend to prove that these manifestations have their origin in the fetus and placenta.

Wolff Eisner has proved positively that during pregnancy foreign protein substances are continually thrown into the circulation of the mother and that these substances under certain condition bring a state of eclampsia. He contends that eclampsia must be considered as the rarest and most severe form of those symptoms, dependent on the absorption of foreign albuminoids. The consensus of opinion will ultimately establish the fact that the toxæmias of pregnancy are invariably due to a disturbed metabolism or to be more exact, according to Rongy, a loss of metabolic equilibrium in the mother, produced by some foreign substance originating in the fetus or placenta. The albuminuric patients who come under observation early in their pregnancy are the ones that rarely give much trouble. On the other hand the explosive cases are much to be feared. The former readily respond to diet, hot packs and purgation especially when the subjective symptoms are mild. The explosive cases require more heroic measures. The patient who presents albuminuria of slight or moderate degree with few or no kidney elements and no uremic symptoms at a time before the viability of the child should have close observation, restricted diet and an occasional purge of calomel. This will usually carry the case along nicely. In a patient, before the viability of the child, with much albuminuria and many kidney elements, reduced quantity of urea and urine, but no uremic symptoms, we have a more severe problem, for uremic symptoms with high blood pressure may occur at any time. This is a very serious condition, purgation and restricted diet, rest in bed and close observation may clear up the condition. We

*Read before the Duval County Medical Society, February, 1915.

now come to the patient in which the child is viable and there is an increasing and severe albuminuria and many uremic symptoms as shown by a partial blindness, headache, convulsions and even coma. If convulsions have not set in and absolute rest, calomel, lavage of stomach and rectum, morphine, chloral, veratrum viride and a milk diet have no effect in staying the severe symptoms we should induce labor.

Time is an important factor and if we miss our chance by an early induction of labor, convulsions and coma may supervene and we are forced to a Cesarean section. The time has now come when we must empty the uterus and do so with as little injury to the mother as possible. When convulsions have supervened the classical Cesarean section has been my choice. If there are lucid intermissions and the patient talks and acts sensibly you may make efforts to carry her along by the use of calomel and enemas, veratrum viride, morphia, etc. When, however, there are no lucid intervals and coma is deep and lasting in spite of blood letting, it is a good rule to proceed to a Cesarean section because it offers the mother and child the best chances for life and is the least mutilating of all procedures for the mother. A forcible delivery by vagina subjects her to no end of severe and incurable injuries and usually kills the child. Forcible delivery or dilatation, no matter how accomplished, means injury to the cervix, broad ligament, vagina and the pelvic floor, and is commonly irreparable. In the more fortunate condition, when the patient is in labor and has her convulsions or even coma with a full dilatation or retraction of cervix, chloral hydrate, morphine, venesection or veratrum viride, followed by the forceps, gives both mother and child a good chance.

PROPAGANDA FOR REFORM.

BANNERMAN'S INTRAVENOUS SOLUTION.—This solution was refused recognition by the Council on Pharmacy and Chemistry because

vague, indefinite and misleading statements were made regarding its composition, because it was recommended for anemia, tuberculosis and syphilis under grossly exaggerated and unwarranted claims and because the intravenous injection of complex and indefinite mixtures is unscientific and dangerous. The proprietors having submitted to the Council a revised statement of composition and a revised advertising circular, Bannerman's Intravenous Solution was again refused recognition, partly because the statement of composition was unsatisfactory but mainly because of the unscientific character of the solution and the unwarranted therapeutic claims which are made for it. (*Jour. A. M. A.*, Jan. 2, 1915, p. 70.)

ECHTISIA, ECHTHOL AND ECHITONE.—Echtisia (Wm. S. Merrell Chemical Co.), Echthol (Battle and Co.), and Echitone (Strong, Cobb and Co.) are proprietaries, each of which has echinacea as its chief constituent. In 1909 the Council on Pharmacy and Chemistry reported that the extreme and extravagant claims which are made for this drug are not supported by evidence. Echinacea is not often prescribed under its own name but is commonly employed in the form of proprietaries which in addition to echinacea contain other little used or obsolete drugs. To call attention to the unwarranted and often absurd claims which are made for this class of mixtures the Council reports on three of these: Echtisia, which is said to be made from echinacea, wild indigo, arbor vitæ and poke root; Echthol, which is said to be made from echinacea and arbor vitæ, and Echitone, which is stated to represent echinacea, pansy and blue flag. In each case it was found that most or all the extravagant and impossible claims which have been made for echinacea were made for the proprietaries and that in addition almost equally extravagant claims were made for the additional drugs contained in them. (*Jour. A. M. A.*, Jan. 2, 1915, p. 71.)

G. G. PHENOLEUM DISINFECTANT.—This is a disinfecting solution sold by the G. G. Phenoleum Co., New York. It was found ineligible for New and Nonofficial Remedies by the Council on Pharmacy and Chemistry because unwarranted claims were made for it and because the disinfectant power was not stated on the label as required by the Council. (*Jour. A. M. A.*, Jan. 30, 1915, p. 456.)

GERMILETUM is a member of a large class of alkaline antiseptics with excessively complex formulas. The formulas on different styles of Germiletum labels and circulars vary so much that one can not tell what composition the exploiters of it intend to claim for their nostrum. Germiletum is recommended in many conditions and in a way to lead the physician to place false confidence in it.

NEUROSINE, DIOVIBURNIA, GERMILETUM AND PALPEBRINE.—The Council on Pharmacy and Chemistry reports on Neurosine, Dioviburnia, Germiletum and Palpebrine, shot-gun proprietaries typical of the polypharmacy of past decades, put out by the Dios Chemical Co., St. Louis.

NEUROSINE is said to contain, in each fluidounce, "Bromid of potassium, C. P., 40 grains, Bromid of sodium, C. P., 40 grains, Bromid of ammonium, C. P., 40 grains, Bromid of zinc 1 grain, Extract Lupulin 32 grains, Cascara sagrada, fl. ex., 40 minims, Extract Henbane .075 grain, Extract Belladonna .075 grain, Extract Cannabis Indica .60 grain, Oil Bitter Almonds .060 grain, Aromatic Elixirs." No physician would think of prescribing all of the drugs in Neurosine for any one condition. The Dios Company urges the use of this nostrum for a host of conditions and without due consideration of its potent constituents. Not content with recommending the promiscuous use of this already too complex mixture, the Dios Co. advises physicians to combine it with other drugs.

According to the label every fluid ounce of Dioviburnia contains "3-4 dr. each of the

fl. extracts, Viburnum Prunifolium, Viburnum Opulus, Dioscorea Villosa, Aletris Farinosa, Helonias Dioica, Mitchellae (sic) Repens, Caulophyllum Thalictroides, Scutellaria Laterifolia." The label also declares that Dioviburnia contains 18 per cent of alcohol. As the named fluid-extracts in the quantities given require a much larger content of alcohol in Dioviburnia, either the alcohol statement or the formula is incorrect. This complex preparation of drugs, generally considered worthless, is recommended by extravagant and unwarranted claims for a large number of widely differing female disorders. In a way the Dios Co. seems to recognize the inefficiency of Dioviburnia, for it frequently suggests that it be used in combination with drugs of known value.

Palpebrine is claimed to be a solution of stated amount of morphine sulphate, zinc sulphate, mercuric chloride, boric acid and salicylic acid. It is termed "A Reliable External Ocular Antiseptic." It is asserted that "with the assistance of Palpebrine the general practitioner can successfully treat all cases of external eye disease ordinarily encountered in his practice." Even more dangerous is the recommendation of Palpebrine for the prevention of ophthalmia in the newborn. (*Jour. A. M. A.*, Jan. 9, 1915, p. 165.)

HAYDEN'S VIBURNUM COMPOUND.—This preparation, according to the advertising matter, depends for its action on Viburnum opulus, Dioscorea villosa and aromatics. The label admits the presence of 50 per cent alcohol. Its use is advised in the treatment of female disorders, cramps, etc. A report of the Council on Pharmacy and Chemistry states that, even if it contains the ingredients claimed (it has been reported that Viburnum opulus has not been on the market for years), the therapeutic action of the preparation depends almost entirely on the alcohol which it contains. The Council

fears that the use of this preparation may initiate the alcohol habit in girls and women and publishes its report as a protest against its use. (*Jour. A. M. A.*, Jan. 23, 1915, p. 359.)

PEEBLES EPILEPSY CURE.—The Dr. Peebles Institute of Health, Ltd., Battle Creek, Mich., advertises an "epilepsy cure." The "treatment" was examined in the A. M. A. Chemical Laboratory. It consisted of two bottles, "No. 1" and "No. 2." "No. 1" was a liquid containing extractive matter, had an odor resembling celery and valerian and contained 11.40 per cent absolute alcohol. "No. 2" was a liquid, having a valerian-like odor and containing as essential constituents ammonium bromide and potassium bromide, equivalent to 16.8 gr. potassium bromide per fluidram, the recommended dose. Thus, the treatment consists essentially of bromides and is, in no sense, a cure and not free from danger. (*Jour. A. M. A.*, Jan. 30, 1915, p. 455.)

PRUNOIDS.—Prunoids (Sultan Drug Co.) are tablets said to be "Made of Phenolphthalein (one and one-half grains in each), Cascara Sagrada, De-emetinized Ipecac and Prunes."

The A. M. A. Chemical Laboratory reported that Prunoids appeared to be essentially a phenolphthalein tablet. The Council on Pharmacy and Chemistry held Prunoids in conflict with its rules because the statement of composition was incomplete and therefore meaningless, because unwarranted therapeutic claims are made for them, because the name "Prunoids" does not indicate the chief constituent but gives the false impression that they depend on prunes for their effect and because it is irrational to prescribe a well-known drug under a misleading name. (*Jour. A. M. A.*, Jan. 2, 1915, p. 71.)

PHYTIN AND FORTOSSAN.—Phytin, sold by A. Klipstein and Co., New York, is an organic phosphorus compound, the acid calcium-magnesium salt of phytinic acid.

The Council on Pharmacy and Chemistry rejected Phytin because unwarranted and exaggerated therapeutic claims were made for this product, based on the entirely undemonstrated assumption that phosphorus is assimilated only from organic combination; that a long list of diseases are due to deranged phosphorus metabolism and that such diseases are benefited or cured by Phytin. The Council also refused recognition to Fortossan, a preparation of Phytin and sugar of milk. (*Jour. A. M. A.*, Jan. 30, 1915, p. 456.)

RADIO-REM.—The Radio-Rem outfit is advertised by Schieffelin and Co. It is said to produce water charged with radium emanation by inserting rods stated to be coated with radium sulphate in water. Not only is the internal use of radium emanation without proved value, but the amount of emanation said to be produced by the apparatus is far below the amounts generally used by those who believe in its efficacy. It is claimed that this outfit supplies a substitute for natural mineral water, but there is no proof that the value of mineral waters depend on contained radium emanation. (*Jour. A. M. A.*, Jan. 30, 1915, p. 456.)

SEDOBROL "ROCHE."—Sedobrol (Hoffmann LaRoche Chemical Works) is stated to contain "17 grains Sodium Bromid, 1.5 grain common salt, fat and seasoning" and to furnish "on solution in hot water, a very palatable Bouillon." The advertising "literature" advocates its use for stage fright and arteriosclerosis and recommends the use of a large dose of bromid in the guise of a cup of bouillon in many conditions. It is even recommended to use Sedobrol in place of salt, simply to flavor food. The Council on Pharmacy and Chemistry held that Sedobrol Roche was unscientific, that unwarranted therapeutic claims were made for it and that there was evident intention to mislead both patient and physician into useless and pernicious medication. (*Jour. A. M. A.*, Jan. 2, 1915, p. 71.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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AN UNJUST TAX.

That altruistic spirit which causes the medical profession to heed the call of the suffering and sick poor and try to relieve their distresses has prompted the doctor from time of old to give freely his services to charity. No law but the love of humanity and the needs of the poor prompted him. From his hours of rest, his meal-time, his sleep, functions necessary to preserve his body and keep his mind active, the needy poor often call him to minister to them in some dire or supposed necessity.

The total amount of charity work done by all the doctors in any fairly well-populated section is enough if paid for to support another physician; would give the poor prompt and effective service, to which by virtue of being human, they are entitled; fall lightly and evenly on all persons in the community; furnish employment for another person not now employed, and remove a heavy load from the shoulders of an overburdened and useful class of citizens.

In most of the towns and counties of Florida no provision is made for medical attention for the indigent poor and this burden falls on the physicians, for some one must do it until the public awakens to its responsibilities and assumes as it ought this community burden. Before the physician can have the privilege of doing this charity work for his community he must at present pay the State \$10.00, the county \$5.00, and the town \$5.00, together with two 25-cent fees for issuance, a total of \$20.50. For this handsome contribution to the State, county and town revenues the physician gets two rather plain documents permitting him to practice his profession for one year and, incidentally, render free service to the poor. These licenses might be said to be an evidence of the gratitude of the people to us for serving the poor without pay, thus saving the precious tax money to spend on other things.

We are seen rushing about the streets answering the calls of the sick and it is

taken for granted therefore that we are very prosperous, when, if people would investigate, they would find that a part of this bustle was in visiting those persons from whom we expect no pay. They would find that it costs just as much per patient, in time and money, to serve them as those that do pay and, therefore, this work costs the doctor money as well as time; that this must be taken from the money received from those who do pay, and, therefore, what seems to the careless observer as an evidence of prosperity really is not. The income of the average American physician is only \$700.00 a year. With this sum he and his family must make a good appearance, look prosperous because expected to, and give liberally to all causes in their community that call on them to do so, and these calls are many.

The state, county or town should assume the whole burden of caring for the needy poor, paying the physician for medical services rendered to them, or repeal the unjust occupation tax now assessed against him. That good doctrine of equal rights to all and special privileges to none should prompt our legislators to provide that all communities should be required to support by taxation—which is the only fair way—the helpless and homeless poor. Then the doctor in paying his taxes would contribute his share in this good cause and would not object to paying an occupation tax.

Every physician in Florida who feels the injustice of this tax as at present exacted should take up the matter personally with his representative and senator at once and explain the unfairness of the tax. We believe that if you will do this the justness of our plea will be heard and this burden be lifted at the coming session of the legislature.

WHY EARLY CANCER IS CURABLE.

"There is still a widespread misapprehension that cancer is a constitutional disease caused by some substance or poison in the

blood. Those who hold this mistaken opinion commonly believe that the disease is hereditary, and in a vague way they think there must be some taint handed down from one generation to another which causes cancer to flourish in certain families. In the minds of people not well informed on the subject this belief may well cause a feeling that it is somehow shameful to have the disease. Such misapprehension, combined with the notion which has long prevailed that cancer is a hopeless, incurable affliction, and that it is of no use to try to have anything done for it, may well account for the extraordinary delay of many sufferers in seeking treatment. A further cause is the fact that cancer, in the early stages, often causes little or no pain. Many a surgeon has wished that cancer, in its early manifestations, might cause the sufferer half as much trouble as a toothache, for then the patient would surely be driven to seek relief so quickly that he or she would be easily cured.

"That cancer is at first a local growth and not a general disease of the system is now clearly established. This fact is of the utmost importance, since it holds out a high hope of cure if the malignant growth is removed before it has time to spread to other parts of the body. Cancer beginning in one spot later appears elsewhere, because small particles or cells are carried away from the first site and start other growths, not because there exists previously some poison in the blood which causes the disease to break out in different parts of the body. The great hope of cure, therefore, lies in removing cancer entirely from the system before it has a chance to spread from its first foothold.

"The reason why so many people came to believe that cancer was a blood disease is doubtless because it was observed to come again in the same or other parts of the body after having been apparently cut out. It was natural to assume that when the disease kept coming back in this manner there must be

some cause or taint in the blood which led to its breaking out in different places much like certain skin diseases. The trouble which started this fallacious reasoning was that in those earlier days cancer was not so well understood as it now is. Surgeons then did the best they knew how, but without the advantages of modern methods they were unable successfully to exterminate the disease. The microscope has now shown us the paths by which cancer cells start their invasion of the body if the first and local appearance is neglected. Modern surgeons are, therefore, repeatedly successful in removing the disease once for all. As an eminent American doctor has well said 'It is not surgery, but *delayed* surgery that fails to cure.'

ENDAMEBAS AND PUS POCKETS ABOUT THE TEETH.

"The recent articles of Barrett, Smith, Bass and Johns, Evans, Middleton and others on the presence of endamebas in pus pockets about the roots of teeth, the relationship of these to other lesions and the use of emetin in treatment, emphasize again the need of co-operation between physician and dentist and better knowledge by each of the field of the other. The dentist," says *The Journal of the American Medical Association*, "has not usually been trained to recognize or appreciate the danger of these chronic suppurations to the general health, and the physician, including perhaps the bacteriologist, has not made a sufficiently close study of the tissues involved in these suppurations to enable him to draw proper conclusions, especially with reference to the complete cure of such cases under the most favorable treatment imaginable.

"It seems desirable to call attention to the peculiar characteristics of the outer hard tissue of the tooth root—the cementum—since a knowledge of the physiologic functions of this tissue in connection with the changes which take place, as a result of sup-

uration, presents the key for prognosis. The dentin, which forms the bulk of the root of the tooth, is covered with a layer of cementum, which corresponds in many respects to bone. The periosteum which lines the bone of the alveolar socket and the cementum covering the root are connected by many bundles of fibers of the presidental membrane, the ends of which are embedded in the periosteum and the cementum, respectively. The function of these fibers is to hold the tooth in position and cushion it against the force of mastication. Lying on the surface of the cementum between the ends of these fibers is a layer of cementoblasts, which correspond to the osteoblasts lying on the surface of the periosteum; and their functions are similar. The important difference between the two tissues is that the cementum does not have a blood supply corresponding to that in bone, nor does it have haversian systems.

"If we do not fully appreciate this difference, we might naturally expect the same response and the same processes of repair in cementum which occur in bone as a result of periosteal inflammations. If the periosteum is stripped from bone, the bone may become necrosed, in which case the activity of the cells within the bone will separate the necrosed area and exfoliate it. Similar changes can not take place in the cementum because of the lack of circulation of blood. When the peridental membrane is stripped from the cementum by suppuration, the cementum becomes a dead tissue which can not be exfoliated, except in its entirety by the removal of the tooth. It is sufficiently porous to become saturated with the products of suppuration, and remains as a constant irritant to the overlaying tissue. Therefore, there is established in each of these pockets a condition similar to that caused by a piece of necrosed bone continuously held in position.

"All of the investing tissues of the teeth—the peridental membrane with its specialized cells and fibers, and the bone of the alveolar

process—must be considered as tooth appendages, since they develop with the tooth and always disappear subsequently to its extraction. Likewise, whenever there is a suppurative detachment of the peridental membrane from the cementum, the fibers of the peridental membrane and the alveolar process corresponding to the area of detachment are absorbed, as has been shown by microscopic examination of the overlying tissue. A careful study of the tissues involved in these chronic suppurations will show that the suppurative process first attacks the tissue at the very surface of the root and strips it off, no soft tissue whatever remaining attached. The involvement of the tissue along the immediate root surface is always in advance of the involvement of the tissues farther removed from the root, and the bone of the alveolar process at any particular level disappears last, apparently by absorption rather than as a direct result of suppuration. This disease should, therefore, be considered a pericementitis, rather than an alveolitis. The bone of the alveolus is practically never laid bare by this disease, but is covered by the soft tissue membrane, which presents a granulating surface to the root. A 'gum boil' or a sinus discharging through the gum seldom occurs; generally these result from abscesses occurring at the apex of the root of a tooth following the death of the pulp.

"On account of the foregoing conditions, the word 'cure' should be used with caution. Evidently some of those who have been studying these cases have considered them 'cured' when no more endamebas were demonstrable, apparently without considering the tissue changes and conditions which prevent the closure of the pocket. A case should not be considered cured, when there remains the constant irritant—the denuded cementum—which maintains the harbor for a reinfection. This fact—that such treatment does not result in permanent cure—seems already partially recognized in a recent report of Bass and Johns, as they

state that reinfection has occurred in about 12 per cent of cases within four weeks.

"It is also stated that a previous injury or inflammation seems necessary 'to furnish a kind of a pocket' in order to provide a nidus for the endamebas, and that they 'are not known to live on open surfaces.' These statements should impress on both dentist and physician the possibilities of greater watchfulness of the gingivæ and more careful management of operative procedures to prevent the injury which prepares the pocket for the endamebas. The pus pocket is always preceded by a gingivitis which may be so insidious as scarcely to attract the patient's attention. Most cases may be cured by very simple procedures, if undertaken previous to the detachment of the tissue from the root."

CONFERENCE OF CHARITIES TO DISCUSS MEDICAL TOPICS.

Announcement has been made from the headquarters' office of the National Conference of Charities and Correction of the preliminary program for its forty-second annual meeting at Baltimore, Maryland, May 12th to 19th. The conference will meet under the presidency of Mrs. John M. Glenn of New York, the second woman president it has ever had.

The program contains the names of over fifty leading charity workers and penologists, and it is anticipated the unprecedented social situation of the present year will result in a conference of unique values. The program on "The Family and the Community" will result in considerable discussion of methods of treating individual cases of poverty, as, for example, in a study of "The Psychology of Co-operation." Prof. Henry R. Seager of Columbia University will give an address on the "Causes and Remedies of Unemployment."

The program of "Health" will be under the chairmanship of Dr. Richard C. Cabot of Boston. It will include a series of dis-

cussions on the social responsibility of the hospital and practical methods of social work in connection with hospitals, the chief speaker being Dr. William H. Welch of Johns Hopkins Hospital, Baltimore. Other subjects will be: "A Pay Clinic for Persons of Moderate Means," "The Distinction Between 'Intensive Cases' and 'Short Service Cases' in Hospital Social Work," and "Social Education of the Physician," the latter subject being treated by Dr. Charles P. Emerson, Dean of the Indiana University Medical School.

In previous years the National Conference has discussed the extent of scientific knowledge of the question of prostitution and the value of current methods of popular education. This year, under the chairmanship of Mrs. Martha P. Falconer, superintendent of the State School for Girls at Darling, Pa., the question will be asked, "How shall the evil be suppressed?" The speakers on this subject include Dr. Katherine Bement Davis, commissioner of corrections of the city of New York, and Miss Maude E. Miner, secretary of the Probation and Protective Association of that city.

The discussion of state care of the insane, feeble-minded and epileptic will occur under the chairmanship of Dr. Walter E. Fernald, superintendent of the Massachusetts School for Feeble-Minded at Waverly. It will include answers to the question, "What is practicable in the way of prevention of mental defect and disease?" and a discussion of "Available Fields for Research and Prevention in Mental Defect." The speakers in this section include Dr. Adolf Meyer of Baltimore, Dr. C. B. Davenport, Cold Spring Harbor, N. Y.; Dr. H. H. Goddard, Vineland, N. J.; Dr. Martin W. Barr, superintendent of the Pennsylvania School for the Feeble-Minded at Elwyn, and Dr. Walter S. Cornell of Philadelphia.

Other divisions of the program are upon children, corrections, education for social work, the family and the community, public and private charities, and social legislation.

ASSOCIATION NEWS.

Dr. E. W. Warren of Palatka attended the Conference on Public Health and that on Medical Education and Legislation, also the meeting of the Federation of Medical Examining Boards recently held at Chicago.

COUNTY SOCIETY NEWS.

BRADFORD COUNTY.

The regular meeting of the Bradford County Medical Society was held at Starke, February 2d, at which the following officers were elected for the ensuing year:

J. P. Tomlinson, Starke, President;

Seebar King, Lake Butler, Vice-President; A. H. Freeman, Starke, Secretary-Treasurer.

W. W. Farrell, Raiford } Board of
J. M. Mann, Lake Butler } Censors.

President Tomlinson appointed a committee on Public Health and Legislation with the following members:

E. W. Warren, Palatka.

E. T. Campbell, Starke.

G. W. Brown, Lawtey.

DUVAL COUNTY.

The February meeting of the Duval County Medical Society was held on the 2d ult. Dr. Frederick J. Waas read an interesting paper entitled "Toxæmias of Pregnancy."

At the March meeting Dr. Tom C. Williams of Washington, D. C., gave a very interesting lecture upon "The Diagnosis and Treatment of Various Spinal Diseases." Mr. Barry C. Smith of the Associated Charities gave an address on the "Economic Side of Sociology."

ESCAMBIA COUNTY.

At the February meeting of the Escambia County Medical Society held on February 9th at Pensacola, the subject of discussion was "Intestinal Stasis, Etiology, Symptoms and Treatment."

Drs. Ames and Payne were elected to membership.

PASCO COUNTY.

At the regular meeting of the Pasco County Medical Society, held at the Hotel Edwinola, Dade City, Dr. DeVane of Trilby read a paper entitled "The Differential Diagnosis of Tuberculosis." At the close of the scientific meeting the society adjourned to the banquet hall where an elaborate dinner was served to the members and visiting physicians. Those present included Drs. DeVane and Byrd of Trilby, Dr. C. H. Scoville of Dixie, Drs. J. T. Bradshaw and J. W. Gatton of San Antonio, Dr. J. F. Corrigan of St. Leo, Dr. Wilhoit of Lacoochee, Drs. Wade and Sistrunk of Dade City, and Dr. J. H. Brownfield, a visiting physician.

PINELLAS COUNTY.

The city of St. Petersburg, recognizing the value of vital statistics, has issued a report of vital statistics for 1914. The report states the following:

"In figuring rates it is only possible to do so within the city limits because one can not estimate with any degree of accuracy the community population. So the city population is a very variable and uncertain quantity owing to the large number of tourists, many of whom are health seekers and so liable to appear in the death reports.

"In deciding the matter of residence or non-residence where there is a doubt we have placed the death to our credit, but six months has been considered as establishing residence.

"The United States Census Bureau estimates our population July 1, 1914, as 5,213, of which 26 per cent or 1,398 are negroes and these are used in arriving at the rates given."

The following is a summary of the report:

"Gross or crude death rate per 1,000...26.7

"Gross White death rate.....25.3

"Gross Negro death rate.....30.

"Resident White death rate.....11.8

"Resident death rate14.4

"Resident Negro death rate.....21.4

"The low resident death rate corroborates what St. Petersburg claims to be—a health resort—and the higher general rates only show that many health-seekers come here—too often too late."

VOLUSIA COUNTY.

At the regular meeting of the Volusia County Medical Society held in DeLand on February 9th, the society went on record in favor of a Medical Defense Fund for alleged mal-practice suits and appointed a committee consisting of Drs. MacDiarmid, Forster and Walters to draw up regulations and to place them before the House of Delegates of the State Medical Society for action in May. The Secretary of the Volusia County Medical Society desires to hear from every county society in the State (within this month), advising whether or not the members favor this action. If the members favor such action we ask them to instruct their delegates to vote in favor of the fund at the coming State medical meeting.

The advantages of the fund are quite numerous. The expense would be less than fifty cents a year per member. It cements fellowship in the society and gives something in return for dues other than the usual returns. The protection it brings is a strong argument to attract new members. The expense is only in proportion to the number insured. It has been decidedly successful in other States where tried. A suit is not likely to be brought when the prosecution finds an organization prepared and ready to meet the attack. In every case the councilors decide upon the merits of the members' case and do not protect illegal abortion cases. Attorneys are supplied always with due regard for the members' wishes as to who it

shall be. The committee also desires to know if the members wish to provide for judgments up to \$500.00. Pennsylvania has set aside fifty cents per member each year for the fund. Since 1905 they have had seventy-four applications for assistance. Some of these cases have been simply threatened cases. In others summonses have been served but the prosecution failed to press the suits. Thus far no judgment has been rendered against a member defended by the society. Only one case has been settled, and that by the executor of the estate of the deceased defendant member, who paid \$50.00 contrary to the societies' wishes rather than have the bother of a trial.

The success of the plan in Pennsylvania is partly due to the fact that the councilor gives his time and services free, charging only for actual expenses. In that State no member in good standing at the time of the alleged mal-practice has ever been refused the defense of the society. In that State the plan does not provide for the payment of any judgments against its members, but does provide for a thorough defense of members sued or threatened with suit for alleged mal-practice, not however including cases usually termed "criminal abortion." Should judgment be rendered against a member in any

case (which has never been done), appeal will be taken to the highest court at the expense of the society.

It is proposed that the first thing for a member to do when threatened with suit for alleged mal-practice is to fill out the application blank provided for the purpose and place it in the hands of the secretary of each county society. This blank, as soon as it has been approved by the censors of the local county society, is forwarded at once to the State secretary. The matter then rests with a committee consisting of the president and secretary of the State society and the councilor of the respective district. This committee has power to act or can refer the matter to the full board of councilors. When a member is threatened with suit, even though he be quite certain it is only a bluff, he should at once make application for assistance as a little delay increases the probability of publicity and lessens the probability of keeping the matter out of court and increases the expense of the defense in case it gets into court. The member is not to engage a lawyer, but the committee of the council will always consider his wishes and his interests in the selection of an attorney.

It is said that one-third of alleged mal-practice cases result from the treatment of fractures and dislocations.

Reviews from Current Literature

THE TREATMENT OF BURNS.

Haas, Sidney V.: *The Treatment of Burns in Children by Exposure to Air.* Am. Jour. of Surgery, 1915, Vol. XXIX, p. 61.

The author discusses the routine method of treating burns at Lebanon Hospital by simple cleanliness and exposing the burned areas to atmospheric air. No dressing of any kind is used other than an occasional gentle cleansing with some simple solution such as boracic acid.

The patients are placed in bed upon a clean sheet and the burned parts are left uncovered. The other parts of the body

are well covered in cold weather. In warm weather it is necessary to keep the bed covered with mosquito netting to keep flies from the wounds.

He states that "the contrast between a burned child treated by this method and one treated by some form of dressing is striking indeed. The terror of the one waiting for the next dressing, and the shrieks which accompany such a dressing, and the comparative air of comfort and well-being of the other, is not quickly forgotten. These children lie quietly in bed, present

good color, smile and play when they can do so without disturbing the burned parts, and take their food with relish.

Nephritis would seem to be less frequent than in cases treated by dressings and, when present, to disappear sooner. The pallor and cachexia of these latter cases is not so noticeable as in those treated by dressings.

The degree of scarring is greatly diminished, the time required for healing is apparently much shorter."

(This method has been in use at St. Luke's Hospital during the past year with most satisfactory results. Patients have been placed upon sterilized sheets, protected by mosquito netting. Mittens have also been placed on the hands to prevent the patients from picking at the wounds. Exposure to sunlight has apparently hastened the healing process. One or two very sluggish cases have responded quickly to treatment by the electric light cabinet. This is no doubt due to the passive hyperemia induced by the heat. In pleasant weather the patients may be placed on the veranda with a bed covering of sterilized sheeting, supported by hoops so that no material comes in contact with the wound.)

R. C. T.

--- **PYORRHEA.**

Bass, C. C., and Johns, F. M.: Pyorrhea Dentalis and Aveolaris. Jour. Am. Med. Ass'n, 1913, Vol. LXIV, p. 553.

The authors state that pyorrhea dentalis and aveolaris is one of the most prevalent diseases of man, and that in their studies they found it present to some extent in more than ninety-five per cent of all adults examined. They further state that more than half of all the permanent teeth are lost from this disease.

The specific cause of pyorrhea dentalis has been determined to be endamebas. These protozoa have been known inhabitants of the mouth for many years but it was not until 1914 that they were recognized as the etiologic factor in pyorrhea by

M. F. Barrett and Allan J. Smith and by Bass and Johns simultaneously.

The authors have studied more than three hundred cases with relation to the determination of the cause of the disease, the nature of the process and the influence of ipecac and emetin as specific remedies. The work has apparently demonstrated beyond all doubt that the *Endomeba buccalis* is present in all lesions of sufficient extent to be diagnosed, and that, as a rule, it is not present in the absence of pyorrhea.

The disease affects primarily the dental and alveolar periosteum. Ulceration with granulation, pus formation, bleeding gums, retraction of the soft tissues with eventual destruction of periosteum and exposure of the roots of the teeth and destruction of the tooth sockets follow in the course of time. The disease usually proceeds slowly and may exist for months or years before the patient suspects its true nature.

As to treatment, the authors state that ipecac and its alkaloids, emetin and cephalin are such perfect endamebicides that nothing better can be hoped for. These drugs are given by mouth, by hypodermic, and emetin has been employed successfully by injection into the pus pockets. Endomebas disappeared from all lesions in from one to three days of treatment in more than 90 per cent of cases. The authors state that the protozoa disappeared in 99 per cent of their cases after six days of treatment, therefore, they conclude that all cases should have at least three days of treatment and none need more than six days.

Coincidentally with the disappearance of endomebas the soreness, pain or discomfort and the amount of pus formed rapidly decreases. Following the disappearance of the endomebas there still remain the lesions which require weeks or months to thoroughly heal and, at the same time, measures must be instituted to prevent reinfection. Proper dental treatment consisting of cleaning and scaling the roots, removing dead and denuded alveolar process and cleaning

out large pockets is essential. The use of a solution of fluid extract of ipecac, one drop to four ounces of water, is valuable in the treatment as well as in the prevention of reinfection. Ipecac may also be given by mouth in the form of ten-grain tablets. Two to three should be given three times a day for from four to six days. The authors state that a preparation called Alcresta ipecac may be given without causing nausea. They advocate for hypodermic medication one-half grain of emetin given daily for three to six days.

(Aside from the importance of pyorrhea in its relation to the teeth, its remote or secondary effects must be borne in mind. Many forms of arthritis, neuritis, infection of tonsils, gastro-intestinal disturbances, etc., are without doubt secondary to pyorrhea alveolaris. Certainly one looks first at the condition of the teeth in every case of chronic arthritis and frequently one sees joints clear up after the primary focus in the mouth has been cured.) R. C. T.

SKIN GRAFTS.

Davis, John Staige: The Use of Skin Grafts in the Ambulatory Treatment of Ulcers. *Jour. Am. Med. Ass'n*, 1915, Vol. LXIV, p. 558.

The author reports splendid results in fifty cases of ulcer treated in the out patient department of the Johns-Hopkins Hospital without confinement in bed. He agrees with the usual teaching that the first essential for success in skin grafting is absolute rest with immobilization, but that by use of the small, deep grafts placed on a properly prepared and healthy granulating surface many ulcers may be healed without the patient having to stop work except for the necessary dressings.

The technic of cutting, applying and dressing the grafts was that outlined by Davis in his article in the *Journal of the American Medical Association*, September 19, 1914.

In the ambulatory treatment the grafts must be secured so that no sliding motion

is possible. This may be done by placing overlapping strips of rubber protective or sheets of paraffined mesh over the grafts, and securing this and the overlying gauze dressing with numerous strips of adhesive plaster. Over this again is placed more gauze and a snug gauze bandage, and finally a muslin or crinolin bandage. If the areas are very large, thin strips of wood may be incorporated in the dressing.

The author concludes that from the results obtained in the fifty cases reported a new method of treatment has been added to our armamentarium which will make for hospital economy, and will also hasten the return of many patients to full wage earning capacity.

R. C. T.

GUNSHOT WOUNDS.

Frank, Jacob: Penetrating Gunshot Wounds of the Abdomen. *N. Y. Med. Jour.*, 1914, Vol. C, p. 1213.

Jacob Frank (Lt. Col. Surgeon-General, State of Illinois) states that there is a radical difference of opinion between civil and military surgeons as to the treatment of abdominal gunshot wounds. The civil surgeon enters the abdominal cavity to search for perforations and to provide for drainage as soon as possible after injury, while the military surgeons "profoundly impress it upon medical officers not to interfere."

Not many years ago the civil surgeons held the same views that the military surgeons hold today but, Frank states, the civil surgeons' treatment changed after noting the marked reduction in mortality through efficient drainage, posture, and intestinal repair.

Military surgeons believe that to operate on field cases means death; that operative treatment in war times is disastrous as statistics prove; that asepsis can not be carried out in the field; that the wounded can not be cared for during battle; that there is grave danger of tetanus.

Frank does not believe that the almost invariable mortality from operative treatment during war is due to operation, but to rough handling in transportation, and to delay often, for a day or more after injury, peritonitis having developed meanwhile.

Frank believes that the application of a first-aid dressing to an abdominal wound, while it may prevent infection from entering, seals up the peritoneal cavity and, if perforation has occurred as it does in ninety per cent of all gunshot wounds, converts the abdomen into a huge incubator, with the most favorable media for growth, where incalculable numbers of bacteria are developed every second, resulting positively, if they are not released, in death.

Frank advocates for all gunshot wounds of the abdomen not immediately fatal, which can not receive the immediate care of a dexterous surgeon, drainage either through the wound of entrance or through stab above the pelvis. The patient is then to be maintained and transported in the sitting position until he arrives at a suitable station, where the attending surgeon may use his judgment as to further procedure. By this method it is stated that gases and bacteria are encouraged to escape to the outside, distention of bowel is lessened, and transportation is less uncomfortable and less dangerous.

(In discussing this proposed procedure with Major Henry Page, Medical Corps, U. S. A., from the viewpoint of military surgery and battle conditions, the major pointed out that immediate drainage, as advocated by Frank, undoubtedly would save life in selected cases were it possible or probable that the work could be done aseptically by trained and competent surgeons familiar with the diagnosis and prognosis of perforating abdominal gunshot wounds. Unfortunately such men are but exceptionally on the firing line; they are in the field, evacuation and base hospitals, which necessarily can not operate in the zone of rifle or artillery fire, and hence are

at varying distance from the fighting men; the field hospitals as close to the firing line as is consistent with safety, evacuation hospitals with the line of communications, and base hospitals at the base often more than a hundred miles from the field.

In battles of the present day first aid must necessarily be rendered principally by the men themselves, by the hospital corps men, and by the regimental surgeons. Often it is impossible to collect and transport the wounded for many hours, sometimes for days and in some instances not at all. The development and extensive use of artillery, with its deadly shrapnel, has rendered transportation of wounded an intricate problem. The losses in the hospital corps have been frightful; both field surgeons and the enlisted personnel have sacrificed themselves in their endeavor to aid and remove wounded under impossible conditions.

It is obvious that for enlisted men, line officers or even hospital corps men on the firing line to attempt to insert drains, by enlarging bullet wounds or by making stab openings, under stress of excitement, and with hands which perhaps have not been washed for several weeks or months, would be productive of more harm than good; tetanus, malignant edema, gas bacillus infection would be added to the colon bacillus infection in many cases. The greatest safety lies in absolute non-interference with wounds on the field; the simple application of a sterile first-aid dressing, and rapid transportation to the field hospitals where emergency operative work and dressing may be done in a surgical manner.

Military surgeons today believe, as do the civil surgeons, in immediate operation on abdominal gunshot wounds with perforation if the case is sent in in the first few hours after injury. This view is evidenced by the report of Major A. W. Williams, M. C., U. S. A., of the work done by Field Hospital No. 3 at Texas City, Texas. During fourteen months forty-seven laparotomies were performed, among them several

cases of abdominal gunshot and stab wounds. Major Williams states that not one stitch abscess or infection developed in four hundred operative cases in which the army iodine technic was used.

It must be remembered, however, that these cases were sent to the field hospital immediately were not subjected to rough transportation, and were of clean-bodied and clean-clothed men. Such conditions would not be often encountered in battle where clothes and bodies are usually foul, and where aseptic surgical attention often can not be given for days. It is in such cases that military statistics show that the best results are attained by non-interference.)

R. C. T.

MILITARY SURGERY.

Hoguet, J. P.: *Observations on Military Surgery in the Early Weeks of the War*. J. A. M. A., 1914, Vol. LXIII, p. 2194.

Hoguet contributes a most interesting and well-illustrated article on his personal observations while with the American Ambulance service in France.

He states that while it was true that in the Russo-Japanese and Spanish-American wars the effect of the modern high-speed rifle bullet was apparently humane and that, in general, the treatment of modern gunshot wounds was simpler than in former years, the present war, after the first three weeks, has demonstrated that with the extensive use of shrapnel, the filthy condition of the men, the impossibility of rapid and efficient transportation of large numbers of wounded, a clean non-infected wound is the exception rather than the rule.

He writes of the arduous life of the soldier in the field, of the lack of facilities for personal cleanliness, or change of clothing, and points out that exposure and hardship has reduced individual resistance to disease or infection. He quotes one of the wounded men who was being undressed on his arrival at a base hospital in Paris in November, who said that the trousers that were then being removed were the ones he

started to the front in in the early days of August, and that he had not had them off since then.

"It is hard to conceive how a bullet traversing such clothes can stay aseptic."

Hoguet states that shrapnel wounds, either those caused by the round lead shrapnel balls or parts of the shrapnel casing, are practically always bruised, lacerated and infected; the infection being caused by soiled clothing, dirt or other infectious material being driven into or brought in contact with the wound.

Gas gangrene has been frequent and is most prone to follow shrapnel wounds of the thigh.

R. C. T.

HAY FEVER.

Emmerich and Loew: *A Further Communication on the Successful Treatment of Hay Fever*. M. m. W., 1915, Vol. 62, p. 43.

The author began the treatment of hay fever with calcium chloride in 1913. Several patients took 15 grains three times a day during the whole year. Their anticipated hay fever attack did not materialize. These patients remained under treatment during 1914 with the same good result. Patients who began their treatment in 1914 also fared very well during that season. Others had used calcium chloride in hay fever with only fair success, but these continued the treatment only during the attack or discontinued it too soon after the attack. The treatment must not be discontinued. During the three or four winter months the dose may be reduced to half the ordinary dose. The long continued use of calcium chloride in moderate doses seems to be harmless as the long use of it by one of the authors (seven years) would indicate.

T. T.

BLADDER IRRITABILITY IN WOMEN.

Cary, Wm. H.: *Bladder Irritability in Women*. Am. Jour. Obst., Feb., 1915, Vol. LXXI, p. 259.

The author includes in his paper those cases of bladder irritability in women which are evidenced by frequency of urination and

dysuria but which do not depend on acute inflammatory conditions. Urinalysis in these cases is normal.

Chronic trigonitis is one of the most frequent causes, often occurring without any previous history of acute bladder trouble. Cystocele, evident only when the patient is standing or sitting, may prevent emptying of the bladder and cause an irritating residual urine which may act as an exciting cause. Continued hyperacidity of the urine or friction of the external genitals are other causes. Frequently a low grade colon bacillus infection of the trigonum or a congestion is responsible. Chronic trigonitis responds readily to instillations of silver nitrate. The two-way catheter of Dickinson is especially useful in treating these conditions.

Posterior urethritis exists much more frequently than is usually supposed. It is easily recognized on endoscopic examination. Women seldom develop posterior urethritis from acute infection but it may be rendered persistent by infection of Skene's glands with colon bacilli or gonococci. It may be excited by prolonged eroticism.

Irritating lesions about the meatus are frequent causes. These conditions may be persistent but usually yield to treatment by the cauterization.

Eversions of the mucous membrane of the urethra, conditions simulating hemorrhoids, and caruncle are all at times initial causes. They may also exist without giving symptoms.

It is rare that other pelvic lesions are causes of bladder irritability except in circumstances in which the bladder structure is involved or pressed upon.

Bladder irritability is frequently considered a pure neurosis but careful study will usually disprove this assumption and show some pathological condition as a cause. G. R. H.

TUBERCULIN TEST.

Fishberg, Maurice: *The Cutaneous Tuberculin Test in Children of Non-Tuberculous Parentage*. Archives of Pediatrics, 1915, Vol. XXXII, p. 20.

In an effort to ascertain whether it is only the child raised in a tuberculous milieu

that runs the risk of infection with tubercle bacilli, the author applied the von Pirquet tuberculin test to 588 children under fifteen years of age in whose home there was no known active tuberculous person.

Of the total number of children examined 52.72 per cent reacted positively.

The proportion of "reactors" rises steadily from the age of one year to that of fourteen years; only ten per cent of "reactors" being found in children under one year, while 75 per cent of children of the age of fourteen responded positively. The author believes that practically all children who give a positive response to the tuberculin test have in their bodies some tuberculous change.

As shown by the tuberculin test children who have not been intimately exposed to tuberculosis contract the disease almost as frequently as those living in a tuberculous milieu.

It is concluded that children under one year respond to the tuberculin test more frequently than is generally supposed; that infections during childhood are altogether harmless in the majority of cases; that infection with tubercle bacilli alone is not sufficient to cause phthisis; that autopsies prove that tuberculous lesions in most people heal spontaneously; that mild lesions are not only innocuous but even beneficial since they protect one from exogenous reinfection with tubercle bacilli. Those persons who have not undergone a mild infection during childhood are apt, when infected later in life, to show a form of tuberculosis of rapidly fatal type; since a virgin, unprotected soil is offered to the tubercle bacilli.

"Chronic phthisis is rather a sign of immunity; only the most vulnerable organ, the lung, is affected," and this organ is but rarely affected in this manner in those who have not been "vaccinated" with tubercle bacilli during childhood.

Hematogenic tuberculosis of a rapidly fatal type, such as tuberculous meningitis, acute miliary tuberculosis, acute pneumonic

phthisis, etc., is rarely observed in those who have enjoyed the protective influence of a mild infection in early life. J. D. L.

COD LIVER OILS.

Street, John Phillips: The Comparative Nutrient Value of Cod Liver Oil and Cod Liver Oil Cordials. *Journal A. M. A.*, 1915, Vol. LXIV, p. 638.

Careful and elaborate experiments were made by the author on rats in order to determine the value of cod liver oil cordials, such as are represented by Hagees Cordial, Vinol, Wampole's Extract of Cod Liver and Waterbury's Compound.

The feeding experiments were made on albino rats who were first placed on a standard ration, free from all fat except lard, for a period of several months or till a failure to maintain weight was indicated. Then a certain amount of one of the cordials was substituted for a portion of the lard in the standard ration, to be replaced later on by a definite amount of cod liver oil. The rats failed to thrive when one of the cordials was substituted for the lard but gained rapidly when the cordial was replaced by cod liver oil. Not only did cod liver oil show a marked superiority as a source of nutriment over the four cordials mentioned, but it also showed a remarkable reconstructive and recuperative quality in that it enabled rats to gain rapidly after having suffered from a deficiency in nutriment when fed on the cordials. J. D. L.

YAWS IN THE UNITED STATES.

The Occurrence of Yaws in the United States. Wood, Edward J., *The American Journal of Tropical Diseases and Preventive Medicine*, 1915, Vol. II, p. 431.

Wood in an article of several pages with three illustrations reviews the subject of yaws in the United States. He gives the history of a case in a young white child that was born in North Carolina of parents who had always lived in that state and at no time had there been a contact with any one from the West Indies, or other sections where yaws is known to occur. The writer says, "Since studying the condition more

fully, I am inclined to suspect that we have been overlooking yaws and that among the negroes the disease has occurred in the South frequently and has been counted as syphilis." Wood defines yaws as a tropical disease occurring chiefly among people of African blood. It is characterized by an eruption assuming the character of a granuloma and is infectious by direct contact through any abrasion of the skin. In many respects resembling syphilis, with which it has been confused until recently and, like syphilis, it is due to a spirochæte, the *Treponema pertenue*, which is only distinguished from the *Treponema pallidum* with difficulty. A very complete bibliography is appended to the article.

J. L. K-S.

SERODIAGNOSIS OF RABIES.

Wohl, Michael G., *American Journal Medical Science*, Vol. CXLIX, p. 47.

On account of the delay often experienced in the diagnosis of rabies by other methods, a specific serum reaction would be a desideratum of great importance. Wohl suggests the application of the principle of the Abderhalden reaction to rabies. He suggests that the virus being present, changes in cellular metabolism will result in the formation of "protective ferments." The detection of these ferments in rabies constituting the basis of his investigations.

The experiments consist of inoculating two groups of rabbits, twenty in all, with fixed virus. Blood was taken from the rabbit before inoculation and on each succeeding day for seven days. Brain tissue of a rabbit that died of rabies was used as the substrata in the tests, corresponding to the placental tissue used in the Abderhalden reaction. The substrata was prepared in the same way as the original reaction.

Wohl concludes that the reaction may have some application to the diagnosis of rabies, having obtained reactions as early as the third day after inoculation. Sera of healthy rabbits cause cleavage of brain tissue, but to a slight degree. H. H.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, April, 1915

Number 10

ORIGINAL ARTICLES

BONE TRANSPLANTATION.*

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This is the era of tissue transplantation, and no one can foretell what the final possibilities may be. It is bone transplantation that has met with the most success, and is today probably the subject of paramount interest to the surgeon.

It was Ollier who first conceived the idea of filling in bone defects with bone transplants. But he worked in the pre-aseptic period, and his results were necessarily discouraging. So that for a long time this subject was dropped and his work almost forgotten. Later, Senn, probably inspired by Ollier's work, did much toward the development of our present knowledge of bone regeneration by the use of decalcified bone chips. The success which he met was most probably due to the osteo-conductive power to the chips, as well as the osteoblasts which they contained.

This brings us to the discussion of the respective functions of bone and periosteum in bone regeneration. Auxhausen taught, and his disciples still contend, that the power of bone regeneration is in periosteum. McEwen and his followers believe that the osteoblasts are contained in the bone, and that the periosteum is merely a limiting membrane, thus limiting the growth and moulding the shape of the bone. And it was this idea that prompted surgeons, until recently, (many still do,) to preserve a periosteal covering for the stump of an amputated bone. There are those who be-

lieve with McEwen that the osteoblasts are limited to the bone itself, but that the function of the periosteum is to furnish nutrition to the bone. Phemister, after months of diligent work in experimentation on dogs, concludes that both bone and periosteum contain osteoblasts: and, therefore, under favorable conditions, capable of bone regeneration. Murphy teaches that bone transplants are osteo-conductive, and not osteogenetic. Which of these views is the correct one must be left to the laboratory of experimental research. It is interesting from an academic standpoint only. For whether we believe that the power of regeneration is in the bone itself and that the periosteum assists only by promoting nutrition, or that the bone merely serves as a scaffold for osteoblasts from the periosteum, this much we know,—that the transplanted bone has more chance of surviving, and regenerates more rapidly, if both bone and periosteum are transplanted.

One of the chief uses of the bone transplant is to fill the gap formed in the shaft of a long bone either by injury or osteomyelitis. And it is a great relief to the surgeon to be able by this means to restore to his patient a functioning limb, where formerly he was forced to do an amputation, or at best to have a frail limb left. The object of this paper is to make a plea for the conservative work in bone surgery.

Barnes, of Chicago, reports a case of a lady who was run down by an auto truck and about five inches of one tibia ground up. He removed all the bony fragments, leaving a gap in the shaft of the tibia. He then selected one long splinter of bone which he had removed and placed it back

*Read before the Escambia County Medical Society at Pensacola, March 9, 1915.

in the gap. The result was regeneration of bone along this autogenous transplant. I have here some pictures of a case reported by Oechner, of New Orleans. This case is particularly interesting to me, because she was under my observation during the entire time, and in my charge for several months. It is a case of complete destruction of the shaft of the tibia for nearly its entire length, as a result of osteomyelitis. A transplant was taken from the opposite tibia, and the gap filled in. The graft was successful, and it is only a matter of time before the patient will have a functioning leg.

Not only may bone transplants be used to bridge the gaps in long bones, but where large portions of the cranium have been lost either through injury or operation for malignant disease, the defect has been filled in by autogenous transplants. Albee has transplanted a strip of bone from the tibia to the spinous processes of vertebrae in Potts disease. The transplant extends from the sound vertebra above to the sound one below, thus immobilizing the diseased vertebrae. And as we all know, when you immobilize a tuberculous bone, you have gone a long way toward a cure, especially if done early in the disease. One of the big advances in surgery was when Mr. Lane began to use his now famous metal plate to hold in apposition the fragments of a fractured bone. But the surgical world has recognized since the beginning of its use that the metal plate is not the ideal one, and has been looking for an absorbable material to take its place. While so far no other plate has been found to replace it in all conditions, under favorable circumstances autogenous bone plates have been used with success, and in those cases where it may be used, there is no doubt as to its advantage over the metal plate.

Having an indication, the next question is: From where shall the graft be taken?

Experiments have shown that autogenous grafts, usually from the tibia, are most successful; that those from the same species act in the same way but more slowly, and that from different species usually act as would a foreign body.

The technique is probably familiar to all, and I wish here merely to lay stress upon a few points, namely:

First: In no field of surgery is such asepsis required. The surgeon who considers that the asepsis which is good enough for the peritoneum is good enough for bone work, is certain to have many disappointments and failures. The surgeon may make many breaks in his asepsis in doing abdominal work and get by with it, for we know that the peritoneum is capable of taking care of a certain amount of infection. But it requires the utmost nicety of asepsis to do successful bone work. Infection usually results in the death of the transplant. The more successful surgeons begin where possible to prepare the limb at least forty-eight hours before operation by wrapping the limb in sheets saturated with strong antiseptic solutions. On the morning of operation, the limb is washed off with benzine, thoroughly painted with tincture of iodine, and then wrapped in a sterile sheet. The incision is made through the sheet and skin. The sheet is then sutured to the skin. No instruments are handled with hands, but are handed to the operator with a special instrument, and when the operator uses the instrument once, it is discarded. So that nothing which has been touched by the hand is introduced into the wound. To those accustomed to abdominal work, this looks unnecessary, or even absurd. But it is not possible to carry asepsis too far to obtain the best results in bone work.

Second: An important phase in the technique is perfect hæmostasis. For the preservation of nutrition and the re-establishment of circulation is essential to the life of

the transplant. Before the circulation is re-established, the nutrition is kept up by the permeation of the transplant by blood serum, and the presence of blood clots seriously interferes with the free permeation by serum.

Third: The transplant should preferably with the transplant is essential to its nutrition.

Summary.

First: Bone transplantation is no longer in the experimental stage, but a well established surgical procedure of undoubted value.

Second: It has been used successfully to fill gaps in bone, to immobilize the spine in Potts disease, and in some conditions to replace the Lane plate.

Third: The transplant should preferably be autogenous. If this is not practicable, it should be from a like species. It should contain both bone and periosteum.

Fourth: The main points in technique are: the most rigid asepsis, thorough hæmostasis, and good coaptation of transplant with soft parts.

ASEPTIC NURSING.*

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Of the so-called contagious diseases with which our hospitals usually deal, the etiology of only one, namely diphtheria, has been demonstrated, and with the possible exception of this the same ideas of air-laden infection are entertained about them.

I will present to you evidence from hospitals doing aseptic nursing showing that if they are transmitted by air at all, it is to a very limited extent. Contact infection is the most obvious mode of transmission of the infectious diseases. One reason why

contact infection has been neglected has been the undue emphasis laid upon other modes of transmission. Formerly air infection was considered of great moment, and as this fell into disrepute undue weight was attached to water and milk infection, partly no doubt owing to the dramatic character of so many outbreaks.

Chapin of Providence, in his book on sources and modes of infection, states:

"Probably the chief vehicle for the conveyance of nasal and oral secretions from one to another is the fingers. If one takes the trouble to watch for a short time, his neighbors or even himself, unless he has been particularly trained in such matters, he will be surprised to note the number of times that the fingers go to the mouth and nose. Not only is the saliva made use of for a great variety of purposes and numberless articles are for one reason or another placed in the mouth, but for no reason whatever and all unconsciously, the fingers are with great frequency raised to the lips or the nose. Who can doubt that if the salivary glands secreted indigo the fingers would continually be stained a deep blue, and who can doubt that if the nasal and oral secretions contain the germs of disease these germs will be almost as constantly found upon the fingers? All successful commerce is reciprocal and in this universal trade in human saliva the fingers not only bring foreign secretions to the mouth of their owner, but there exchanging them for his own, distribute the latter to everything that the hand touches. This happens not once but scores and hundreds of times during the day's round of the individual. The cook spreads his saliva on the muffins and rolls, the waitress infects the glasses and spoons, the moistened fingers of the peddler arranges his fruit, the thumb of the milkman is in his measure, the reader moistens the pages of his book, the conductor his transfer tickets, the "lady" the fingers of her glove. Everyone is busily engaged in this distribution of saliva, so that the end

*Read before the third annual meeting of the Florida State Association of Graduate Nurses at Jacksonville, Fla., March 4-6, 1915.

of each day finds this secretion freely distributed on the doors, window sills, furniture and play things in the home, the straps of trolley cars, the rails and counter and desks of shops and public buildings and indeed upon everything that the hands of man touch.

What avail it if the pathogens do die quickly? A fresh supply is furnished each day."

The French were first to doubt the air-borne theory of disease and the importance of controlling contact infection. To Graucher of Paris belongs the credit of being one of the first to put these ideas into practice. He isolated contagious diseases in the wards of a general hospital. Wire screens were placed about the beds to indicate that certain precautions were to be taken in handling these patients, namely the observance of strict asepsis. From 1890 to 1900 among the 6,451 patients admitted to Graucher's wards diphtheria was introduced 43 times and only once did the disease develop in the ward. Scarlet fever was introduced 19 times and but 7 cases developed. Less success was obtained with measles, although the infections were reduced two-thirds, but the evidence was conclusive enough to convince Graucher that even measles is not spread by air.

The numerous infectious hospitals in England and France which have taken up the work have developed different methods of separating patients. Out of Graucher's methods grew the barrier system. This is the method of isolating patients in a common ward. In the beginning, the beds were surrounded by sheets kept wet with bichloride of mercury. Within this enclosure the patient's nursing articles were kept and asepsis was strictly observed. At present the wet sheets have been dispensed with and a piece of tape is stretched about the bed. In one hospital, two uprights are set on the floor, one on each side of the foot of the bed, and a cord of colored tape to indicate

the disease is stretched between. These signs are merely to indicate to the nurses that precautions must be taken.

Another method is the so-called cubicle system, the system employed in the Isolation Pavilions at St. Luke's Hospital. The cubicles are small rooms with partitions more or less complete. They are of silicon plaster, or glass or a combination of both. The rooms are arranged on either side of a common corridor. Each room is provided with a wash basin without any plug in it and levers operated by the elbows for turning on or off the water. There are two hooks on the wall, one for the visiting physician's and one for the nurse's gown. Over the wash basin is individual paper toweling. The walls of all the ward buildings are painted with an enamel finish so that soap and water can be freely used without damage.

The doors of all the rooms are always left open unless there is some unusual reason for closing them as our theory is based on contact infection and not air-borne.

Every new nurse and employee who comes to the wards is thoroughly impressed with the idea that if he acquires infection it is most likely his own fault and probably due to putting his fingers or something else contaminated into his mouth. He is impressed with the fact that infectious diseases are taken and carried by contact and not by air infection.

I will not attempt to present to you all the details of our technique but will outline the more important.

When a nurse goes on duty she goes to the dressing room where she puts on her ward clothes. She changes her dress, cap, apron and bib only. When going off duty she removes her ward clothing first, washes hands and face and then puts on uniform that has not been worn in the ward.

We confine the infection to the rooms immediately occupied by patients. We expect that the corridors, serving, kitchen,

linen room and bath are as safe and free from contagion as those of any general hospital.

The same nurses care for the patients on a single floor regardless of the variety of infections. The nurse washes her hands with soap and running water using a brush for nails and palms and dries them on an individual towel every time she touches the patient or anything in the room. If she comes into close contact with the patient she puts on a gown reserved for that case.

Each patient is supplied with a thermometer, basins, ice-bag, heater, and so forth, everything necessary for constant use on the patient. All dishes and nursing apparatus coming from these patients are put directly into a sterilizer, if steam can be used, or 1/20 carbolic for rubber goods.

When a patient is discharged, the linen in his room is sent to the laundry, the mattress and pillows to the steam sterilizer and nursing articles are sterilized. The bed, table, chair, floor and walls within easy reach are simply washed with soap and water. Preferably the room is aired for 24 hours, but if needed we do not hesitate to put a patient into it immediately. Fumigation is never done.

Every discharged patient receives a thorough soap and water bath, including a shampoo. The clothing having been sterilized by steam.

You will have noticed that we do not use any disinfectant solution for the hands. It has seemed that if we could make it convenient enough so that every time hands became infected they would be washed with soap and water, it would be sufficient. There is no antiseptic solution which is efficient under immersion of less than one minute. It is impossible to get so long an immersion after washing, done by busy nurses. What is more important, all the solutions injure the hands, setting up a dermatitis, which is a good soil for infection to linger upon and experience has shown that the mechanical

cleansing of the hands is sufficient if conscientiously carried out.

The success of the methods described is well shown by the published figures. At the Pasteur Hospital from October 1, 1900, to April 19, 1903, the following cases were received:

Diphtheria	443
Sore throat	166
Small-pox	524
Chicken-pox	55
Measles	126
Scarlet fever	92
Erysipelas	163
Phlegmon of tonsil	20
Other diseases	219
Mothers with infants	192

Such a combination furnishes a remarkably fertile field for cross infections. During the next year 750 cases were admitted.

During this whole period the only cases which developed in the hospital were 5 of small-pox, 2 of erysipelas and 1 of diphtheria, and since 1904 the percentage of cross infections has been less than 0.1 per cent.

Thompson, of the North Eastern Hospital, London, reports on an experience of two years with the cubicle system. To the cubicles 1,290 patients were admitted.

The following cross infections have been developed:

Scarlet fever, five.

Rubella, three.

Measles, two.

Whooping cough, one.

Chicken-pox, three.

Diphtheria, two.

The cubicle partitions and screens certainly cannot prevent infection if the nurses, without taking proper precautions, pass from one case to another. This is shown by the constant development of cross infection in the ordinary hospital. It was in the Pasteur Hospital that the principles of medical asepsis were first fully appreciated and carried out in a practical manner.

SPINAL EPILEPSY WITH REPORT OF CASE.

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Welaka, Fla.

Formerly Medical Superintendent New York State Colony for Epileptics; Ex-President National Association for the Study of Epilepsy; Member New York Academy of Medicine, etc.

Hughlings-Jackson, the distinguished English epileptologist, wrote a monograph some years ago in which he sought to classify epileptic convulsions into three groups, according to the area of the brain involved during the fit. He divided the cerebrum and its correlated parts into three different "fit levels," as he termed them, as follows:

Convulsions springing from the cortex and accompanied by the usual motor and psychic manifestations due to irritation of this area, were termed "high level" fits.

Convulsions having their base in the central bodies, and the association paths that lead to and through them, were termed "middle level" fits; while those dependent upon some lesion in the upper segment of the spinal cord adjoining the floor of the fourth ventricle and the point of decussation of the fibres in the cord were termed "low level fits."

Marshall Hall used the term spinal epilepsy to mean a species of convulsions in which sphaggarismus, odoxismus and laryngismus succeeded each other in regular order.

Sir Wm. R. Gowers and Brown-Sequard have both written of it as bearing only a superficial resemblance to true epilepsy.

Brown-Sequard observed the presence of epilepsy in guinea pigs in which experimental lesions of the cord had been made, and Féré states that in man a number of cases of epilepsy have been observed following compression of the cord by a tumor, by hemorrhage, by traumatism, or by some disease of the vertebræ.

Multiple sclerosis of the brain and spinal cord may give rise to a form of motor

epilepsy in which the lower extremities bear the brunt of the fit in the form of clonic movements only; tonic contractions being entirely lacking.

I once saw a letter carrier suffering from multiple sclerosis of the brain and cord, who had convulsions and who had been trephined under the belief that he suffered from a brain tumor. His fits were largely spinal in character.

Spinal epilepsy is more common in males than in females. The age of greatest occurrence is from the twentieth to forty-fifth year, though it may occur in younger persons suffering from some systemic malady like rickets or tuberculosis.

It is nocturnal in point of time, rarely the reverse. In some instances it is post-dormital; in a few it is systematically dormital; never occurring except just as the patient falls into the unconsciousness of sleep.

Unlike true epilepsy, it is not *per se* dangerous to life. The fit itself in true major epilepsy is the cause of death of four epileptics out of every one hundred who die. But there is this about spinal epilepsy that makes it a very grave malady at times, *i. e.*, when it is due to some serious lesion of the cord, such as hemorrhage, caries of the vertebræ, tumor, etc.

I recall the case of a man of thirty-five, a well-to-do merchant, who suffered from a tumor of the cord, with a slowly developing paraplegia that became complete some three months before he died. He suffered from spinal epilepsy in a most pronounced and violent form. During a paroxysm he would often literally kick all the bed clothes from the bed on the floor.

Spinal epilepsy has no aura and of itself, independent of any serious lesion of the cord, is never dangerous to life.

Four per cent of epileptics who die do so while in a convulsion, the muscles of respiration being locked so rigidly and for so long a time, death follows from asphyxia. But in

spinal epilepsy the respiratory center is above the lesion in the cord in which spinal convulsions have their origin.

Men suffer from it more than women; in fact I have never seen a case in a woman.

In some cases there is renal incontinence during the paroxysm.

The patient never completely loses consciousness. He can hear anything said to him, can understand it fully, but his power of co-ordination over the muscle of facial expression and of speech is impaired or lost.

Characteristics.

Spinal epilepsy has two distinct characteristics. The first is the clonic movements of the legs, without any tonic contraction whatever; the second is the lack or loss of consciousness during or following the fit. The leg movements consist of a violent jerking, almost rhythmic in character and frequently they are of equal degree in both legs—though in some cases one leg is more active than the other. The legs are drawn up at the knees and both are shot forward with great force.

A young man of twenty-two, a first-class baseball player and a steam fitter by occupation who was under my care, slept on an iron bedstead that had one-half inch iron spindles at head and foot. They were some six or eight inches apart at the foot. So violently did he kick these during his paroxysm that nearly all were bent out of position and the plaster was kicked from the wall at the foot of the bed over a considerable area.

The latest case I have seen is that of a colored man of forty-five years, a mulatto, who admits himself a product of miscegenation, his father being white. His ancestry is good. He is of robust build and works in a lumber camp as a laborer. No stigmata of degeneration, nothing of import in family history so far as could be ascertained. Had white swelling on left leg when a boy. Caries of tibia at junction of lower and middle third followed, necessitating surgical atten-

tion and the removal of "more than a dozen little pieces of bone."

Leg scars at that point are prominent at this time. Careful neurologic examination failed to show any disease or disorder of the nervous system, save a complete, an absolute loss of both patellar reflexes. Patient walks with a heavy, jarring gate, planting his feet flatly down at each step. Has been ill nine months, and declares he has had more than 280 "jerking spells" in that time. Movements begin in left leg a second or so before they do in the right and last twenty to thirty seconds, after which his legs feel "plumb heavy and dead." This feeling passes away in eight to ten minutes and then he is able to go immediately to sleep. Sometimes the paroxysms come the instant consciousness is lost in sleep.

In some cases of the kind I have tried the experiment of having the patient change his day into night and *vice versa*, so far as sleep is concerned, but the attacks followed the sleep period just the same.

It is a well-known fact that the mere existence of consciousness—of being awake—the mind being active, is sufficient to ward off epileptic convulsions in some cases. Heart, lungs, liver, kidneys, and other organs normal in case in question. Good appetite and unimpaired digestion. Patient speaks in low, level tone of voice—the "plateau voice" of the epileptic. No aura of any kind; none of the special senses involved. Blood pressure with modified Riva-Roca instrument, 130. Facilities not at hand for making X-ray of injured leg. This will be done later.

Treatment.

Being fully satisfied that my diagnosis of spinal epilepsy was correct, indeed, feeling that this was in fact a classical instance of that form of the disease, I put the man on an emulsion having for its base the most valuable brain sedative used, in my judgment in epilepsy, to this time, *i. e.*, "Bromipin." The emulsion was made by adding in cer-

tain proportions: syr. simplex, spts. menth. pep. and gum acacia. It must be kept in a cool place to prevent fermentation. It gets rancid under the slightest heat, and when it is taken in that condition the patient has difficulty in digesting it, tasting it for twenty-four to forty-eight hours after.

He returned in eight days reporting no amelioration of the symptoms—had suffered one to two attacks every night. Then I began to question the power of the prescription to lessen irritability of the spinal cord centers, though from its use in more than 3,000 cases I knew or rather regarded it the best all-round brain sedative—when systematically and lengthily given. So I stopped it and put him on a combination of the bromid of potassium and bromid of sodium, sixteen grains of the former and thirty of the latter, an hour before meals. He began the new prescription at once. Nine days later he appeared and reported that he had not had a single seizure during the past nine days and nights. Felt better, his legs had more life in them, and he was able to do a full day's work as a laborer.

Of course it is *entirely* too early to say that this well-defined and very happy result is going to be permanent, and it is my rule never to declare a patient cured until he has been free from seizure for not less than eighteen months to two years. Some epileptics can be cured in less than two years, but the number is few.

Author's note. Twenty-nine days after beginning new treatment the patient was still free from attacks.

HEPATO-INTESTINAL TOXEMIA.*

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Hepato-intestinal toxemia is a term first used by us, as applied to a complexity of symptoms occurring in the course of a toxemia arising in consequence of a faulty

metabolism originating in the intestines and its glandular appendages, the liver and possibly the pancreas.

At the very onset we would state that the term is purely an arbitrary one, to be used merely for convenience until further investigations and improved laboratory methods shall give fuller and better knowledge of this term.

Many of the symptoms to be mentioned as occurring in the course of hepato-intestinal toxemia may no doubt be found described under such terms as biliousness, autointoxication, gouty diathesis, etc. We shall find this especially apparent in comparing the clinical description of cases given under the above headings with those described under the acute form of hepato-intestinal toxemia, in this respect I do not wish to be misunderstood. For example, in certain cases the symptom-complex presently to be described as constituting an attack of hepato-intestinal toxemia, if occurring in a gouty person, might with some degree of justice be described as an attack of "gouty toxemia." The present state of our knowledge does not permit us to speak in any certain terms of any specific poison or poisons causing such a toxemia. Indeed, our lack of intimate knowledge as to the causes which produce the morbid phenomena associated with any of the somewhat vaguely hypothetical pathological condition named above, renders the clinical description of such cases altogether unsatisfactory.

Up to the present time only the most meager attempts have been made to associate any definite symptoms with such supposed pathological states.

In the present state of our knowledge we cannot say just what part of the alimentary tract or its appendages are concerned in the production of the pathological products causing the symptom-complex in question. It is highly probable that both the liver and the intestinal tract play a large part in the pathogenesis of such conditions, and there-

*Read before the Escambia County Medical Society at Pensacola, February, 1915.

fore it is practical for us, as clinicians, to group such cases under the term, hepato-intestinal toxemia, which directs attention to this important fact.

We find hepato-intestinal toxemia manifesting itself in both an acute and chronic form. The latter again exhibiting two fairly distinct types, namely: a recurrent or intermittent one in which there are recurring attacks of a mild or severe character with intervening periods of normal health; and a remittent one, in which the patient is never well and suffers constantly from the effects of the poisons, but where at times there are remissions or exacerbations, all the symptoms being more or less severe. The majority of acute cases are seen between the ages 15 and 25, whereas the larger portion of chronic cases are seen between 25 and 50 years.

I see where some one reports a few cases of chronic types in the young, and sometimes the acute type in the old.

No matter what form or type these cases of hepato-intestinal toxemia assume, the quality of any particular symptom may vary, and be more or less pronounced in different individuals. The variation as to the forceful expression of any certain symptom depending not only on the severity of the toxemia, but also on the patient's peculiar susceptibility to poisoning, especially to the effect exerted on his nervous system.

As a rule the chronic cases, especially those of a remittent type, present the most intense circulatory and nervous phenomena, for where hepato-intestinal toxemia has existed for any length of time there is a perversion of metabolism and function which affects the cells of the systems of the body. More especially does this apply to the nervous system, and thus it happens that when hepato-intestinal toxemia has existed for any length of time there must be added to the symptoms, caused by chronic poisoning, those of neurasthenia as well. This, at times, complicates the symptom-complex.

Only experience and a thorough knowledge of the history of a case and of the conditions persisting will permit one to say whether the complexity of symptoms, so frequently met with in these cases, is due to the hepato-intestinal toxemia or to the neurasthenia.

At this point we feel that we cannot emphasize too strongly the fact that many cases of so-called neurasthenia are in reality unrecognized cases of chronic hepato-intestinal toxemia. Such cases if treated for their nervous symptoms alone never get well, drifting from bad to worse, until a more serious condition is the result.

As the symptom-complexity of the attack in both the acute and chronic forms of hepato-intestinal toxemia are practically the same, I shall confine myself to the description of the attacks as seen in chronic cases. These are particularly severe; the circulatory and nervous disturbances in such cases are apt to be more pronounced. Indeed there may be nothing abnormal in the appearance of the patient suffering from the recurrent or intermittent type of hepato-intestinal toxemia. In fact such patients may to all intent and purpose appear well and healthy. They will tell you, however, that they are subject to "peculiar attacks," which when they occur, last for a period of several days or many weeks, when by treatment they disappear, only to reappear after a long or short period of good health. Generally, such cases ascribe their attacks to indiscriminate in diet or to worry or mental strain, but more often than not they are quite unable to account for the recurrence.

In the remittent form of chronic hepato-intestinal toxemia, we see mild and severe types of the ailment. In the former, the general condition may be very fair and to all outward appearance little seemingly ails the patient, their symptoms being subjective rather than objective. Such is the case, however, only with those who suffer from the mildest degree of the condition, or with one in whom it has lasted only a short time. Yet, they speak of their condition as one of

constant ill-health, with certain periods recurring at intervals of days or weeks when they feel depressed physically and mentally, and at such times, indeed, so utterly wretched and deplorable, they feel as if they no longer wish to live. Although the majority of cases present a rather melancholic, listless or depressed attitude at times the reverse of this may be seen, when the case is complicated by neurasthenia.

As above stated it is only in the very mildest types of these remittent cases that a normal appearance is maintained. Generally such cases present the appearance of patients suffering from a secondary anemia, and in addition they are sallow. The conjunctiva show a sub-icteroidal tint. They are not generally jaundiced, whereas the term sallow and sub-icteroidal are applicable. The tongue is coated yellowish white or yellowish gray. This coating is generally thick and pasty. It may extend over the entire tongue or be limited to the back of the organ. The tongue is clean in certain cases when there is a complicating hyper-chlorhydria or where a hypersthnic gastritis exist. Often, the tongue is peculiarly dry. Such patients may be fairly well nourished, but as a rule they show more or less emaciation, for when the toxemia is severe or has lasted for a long time, it seriously affects metabolism; the patient presenting marked emaciation and of such a peculiar color as to excite the suspicion of a malignant cachexia. We have seen patients suffering from chronic hepato-intestinal toxemia, so sallow, so emaciated and weak, with an appearance so simulating a chachexia and evidently so ill they seemed to be suffering from malignant disease. Again, if with such a condition there should be a hypochlorhydria or a myasthena gastrica with stagnation and possibly food retention it may be, for the time being, impossible to decide whether these patients are suffering from a malignant trouble or not; time, only, decides the question. No matter from what type of the disease the patient is

suffering, from time to time there occur exacerbations when many, or all, of the following symptoms manifest themselves:

The acute symptoms may become manifest in one or several ways. The attack may be preceded by several hours of unusual good feeling, the patient feeling more than ordinarily sprightly and energetic, with an increase in appetite and a desire to be up and doing. This good feeling is more apt to occur in the acute form, or the intermittent type of the chronic form. In many instances these patients know by sad experience the wretchedness which follows on the heels of so buoyant a day. However, the period of good feeling may be altogether absent, and the reverse may occur. The patient becomes depressed, listless and drowsy and incapable of any physical or mental energy whatsoever for several hours or days, before the severe symptoms of toxemia show themselves, either following a period of buoyancy or a period of depression or at times occurring independent of either and as a prodromal symptom, the patient may experience an indescribable discomfort in the right upper abdominal quadrant. It is not pain, nor is there any particular spot which is very sensitive to pressure, yet the patient frequently complains. They feel as if they wished to get away from something in that region, and oftentimes they will exert deep manual pressure over this area in order to remove or relieve this peculiar discomfort. This symptom is by no means an uncommon one, and may precede all other symptoms by several hours or longer, at times, however, it may be altogether lacking.

This discomfort in the right upper quadrant occurring with the feeling of depression or a concomitant of both, or finally as a prodromal symptom apart from any other of the above named symptoms. The patient may notice the tongue became coated, his breath heavy, his face sallow, his conjunctiva subicteroidal, and his stools may be light in color, he voids more, or less, urine

than usual, which like the stools, is much lighter in color than normal. Any one of these symptoms may mark the onset of the attack. Sooner or later, when the patient is under the influence of the toxemia some one of these symptoms manifest themselves in varying degrees of severity.

As a rule patients feel decided depression and muscular weakness, may or may not feel drowsy, may or may not have nausea, they very rarely have vomiting and when this does occur, it is more often in acute forms and with younger patients.

They have chilly sensations, and very often find it impossible to get warm, and often complain of dizziness or vertigo. Several or all of these symptoms may be present. Often there are numb sensations in different parts of the body, especially in the legs and forearms or face or the patient may feel as if his legs and arms are no longer a part of himself.

These symptoms may continue until the toxic condition is relieved. If the toxemia is not relieved, the cumulative effects of the poison appear, the severe manifestations, such as marked dyspnoea, severe vertigo, violent cardiac palpitation, and numbness of different parts of the body, become evident. At times there may be difficulty in the enunciation of words, not, however, a true aphasia. The patient's tongue feels thick, he finds it difficult to pronounce words correctly, especially when speaking hurriedly.

During such times the mind is dull and confused, and it becomes difficult for him to remember things, generally finding it almost impossible to concentrate his thoughts, frequently finding it difficult to attend to his own affairs, in fact he seems to be drunk with toxemia, and until he is relieved of this condition, all of these uncomfortable, and at times distressing symptoms continue.

Let us review certain of these symptoms, more especially those of the severer type.

The circulatory and respiratory disturb-

ance may be slight, severe, or entirely absent.

Very frequently dizzy sensations are present, or again a feeling of light-headedness.

This dizziness or light-headedness may be limited to occasions when the patient makes an effort to rise from a reclining or sitting posture. At times, however, these feelings are much more severe. They may prevent the patient from raising his head at all—or may temporarily interfere with his gait. Such patients often bump into doors and walls while walking. This gait combined with all the ill-feelings may alarm them and their friends. The symptoms described will repeat themselves in severe cases in the remittent type, for months at a time, and these cases will feel giddy or uncertain when going down steps. When descending stairs they feel as though they were going to pitch forward and fall.

These symptoms are due to toxemia and to its effects on the brain circulation, patients in this condition, while walking feel as though the sidewalk were suddenly coming up to meet them. It is really difficult with such symptoms, without a most thorough examination, to decide whether they may not be suffering from more serious poisons of the nervous system, or from labyrinth trouble.

Occasionally, as already stated, one of the alarming symptoms to patients is the thickness of speech and difficulty of pronunciation of certain words, especially when the patient tries to speak rapidly. These difficulties of articulation appear about the same time the toxemia causes dullness and confusion of thought. Insomnia and bad dreams, especially the sensation of sudden falling, just about the time the patient falls asleep, is quite a common symptom in these cases.

Gastro-intestinal symptoms. So far as the stomach itself is concerned very little disturbance in the majority of cases, either in the subjective or objective examination.

The only clue to gastric disturbances is the loss of appetite, which occurs during attacks of the intermittent type or during exacerbation of the remittent or chronic type. At times, as a complicating condition, we may meet with a functional hyperchlorhydria or hypochlorhydria and we obtain evidence of severe forms of gastritis. But in all such cases gastritis exists merely as a complication, and never for an instant have we been led to believe that the origin of a hepato-intestinal toxemia was to be traced primarily to a gastritis. So far as the intestinal tract and liver are concerned, it is different. The frequently marked constipation, the various fermentations, the evidence of intestinal putrefaction, the light or clay color of the stools (without jaundice and without bile in urine), the poor absorption of fats, and the discomfort in the right upper quadrant; all of these symptoms point to the fact that the functions of the liver and intestinal tract are seriously disturbed and treatment applied specifically to the liver and intestinal tract confirms this view.

Temperature. More frequently than not, these cases have a normal temperature, or with but a slight rise above or below normal. Some writers say the temperature varies from 99.2° to 101° Fahrenheit, occasionally assuming a typhoidal character, in which we may experience difficulty in differentiating from typhoid fever.

The blood picture. In the milder form of the intermittent type, the blood may present no abnormal features, but in the severe forms of this disease. I am quite sure, there is a change in the blood condition. Not having thoroughly investigated this, I can say but little on the subject but there is always a secondary anemia especially in the severe forms in the long standing cases.

Treatment. First decide if your patient should be put to bed; if the toxemia is particularly severe, the nervous symptoms may demand it; if the anemia is of a bad type, or a severe colitis or enter-colitis complicates the conditions, then the patient should be put

to bed and kept there for weeks or months. The rest cure should be undertaken, removing all home anxieties and restricting communications from friends.

All cases of hepato-intestinal toxemia, in the severe forms, are very difficult to cure in my judgment, especially when they are complicated with neurasthenia and visceral disturbances. Before undertaking to treat a patient with such symptoms it is wise to inform them or some member of the family that it will take weeks or months to effect a cure. It may take a long time to get rid of the toxemia and until you have accomplished this you cannot speak of a cure. Again, the preliminary physical and functional examination should be thorough and exhaustive, requiring several days. The examination should include the blood, urine, gastric contents and feces.

Our first object in treatment should be to rid the patient's system of the poison; second, to prevent, as far as possible, such poisons from accumulating; and third, to build and tone up the system, so that the physiological functions may be carried out in a normal manner.

Treatment is principally eliminative. I have found the following prescriptions of value:

Ext. Nux Vomica.....	.008
Massa Hydrarg.....	.65
Ext. Colocynth Co.....	.32
Ext. Rhei.....	.78
Ft. Caps. No. VI.	
Sig.: One at bedtime.	
Sodium Glycero phosphates.....	1.8
Aqua Dist. gr.....	180.
M. Sig.: One teaspoonful t. i. d.	
R̄ Menthol.....	.26
Bismuth Salicylate.....	.65
M. Ft. Caps. No. ii.	
Sig.: One t. i. d.	
R̄ Sodium phenol sulphate.....	12.
Ess. Pepsin.....	60.
Aqua Dist.....	120.
M. Sig.: Teaspoonful in water t. i. d.	

The diet is most important, milk in some form; buttermilk is better than any. Then prefer skim milk, curd or sweet milk, when used it should be diluted with potassium carbonate or sodium carbonate 3 or 4 gr. to a glass milk. All proteids should be prohibited, and all stimulants like tobacco and coffee and tea are contra-indicated.

CORRESPONDENCE.

To the Editor:

As the session of the legislature is now almost upon us, it would seem a fitting time for a revival of interest in the occupational license tax inflicted upon physicians and surgeons by the cities whose charters have been granted them after the passage of the statute exempting physicians from the payment of such a tax. And now that a large number of the physicians of the State are being "held up" for this unwise and unjust exaction, the subject should be brought home to every medical man in the state, whether he is a member of organized medicine or not.

Feeling a deep interest in the matter, and having been advised by an able attorney of this city that the ordinance framed by the city council for the collection of a license tax from physicians was in conflict with the state statute of exemption, I persuaded a number of local physicians to join me in employing an attorney to test the ordinance in the courts.

Receiving an adverse decision in the local court, my attorney carried an appeal to the supreme court where the case was again decided against the physicians.

Having now dispelled any doubts about the right of a chartered city to impose this infamous tax upon physicians, there remains but one remedy with which to combat this evil, namely, the introduction and passage of a bill bringing the exemption of physicians from taxation up to date.

Our committee of public policy and legislation will have charge of this matter, and

will doubtless introduce the necessary bill; but it behooves all members of the profession in the state to use their influence on the legislators, before they leave for Tallahassee, to prove the right of exemption which we claim.

In this connection I wish to quote from a letter recently received from Dr. George A. Stover, Chairman Legislative Committee, Medical Society of Virginia, wherein he voices the views I have entertained for years, and which proved such an effective weapon in the fight for the same principles we are contending for.

"As Chairman of the Legislative Committee of the Medical Society of Virginia, I have had charge of the fight which we have made continuously for 13 years to have the state license tax repealed in Virginia. For this reason, Dr. Edwards thinks I can give you the information you desire better than he.

"We made our fight and won chiefly on one argument, namely, the important part which the medical profession takes in making effective our public health laws, which are administered through the State Department of Health.

"Inasmuch as the individual doctor is the unit of the State Public Health system, the field agent of the Department of Health, as it were, it would be gross injustice to require this public service and at the same time exact from him a license tax for the privilege. In addition to this, we are required to report all births and deaths and causes of communicable diseases for none of which we receive compensation. We succeeded in convincing our lawmakers of the injustice of this license tax and, furthermore, that it would be for the best interests of the state to foster the spirit of co-operation with the medical profession.

"If your state has a Department of Health and is requiring similar services from her doctors, I think by judicious co-operation on the part of your state and local societies,

you should be able to secure the repeal as we have done.

"If you care to have some literature which we have on the subject, we will be glad to send it to you or render you any other service that may be in our power."

I have hesitated heretofore to publish my own convictions which Dr. Stover has so ably and fully expressed, for fear that my views might be misconstrued as an attack on the State Board of Health. Now, however, the time has come for positive action, and the profession throughout the state should not hesitate to demand such legislation as we are clearly entitled to.

We are all agreed as to the necessity of a proper system of collection and tabulation of vital statistics, and, too, the futility of even expecting anything like a correct report unless the legislature removes existing causes of friction between the profession and the state.

Co-operation is the keynote of great achievements, but injustice invalidates the best law ever placed upon the statute books. Therefore, it is reasonably certain that the physicians of this state will not give their unqualified support to either the county or state health authorities until we are given legal redress from both the license tax imposition, as well as our out of date examining board laws.

Doctors, as a class, are noted for their forbearance and willingness to suffer the imposition of their full measure of life's exactions; but even worms have been known to turn upon their oppressors. "A word to the wise is sufficient."

Yours very truly,

J. HARRIS PIERPONT, M. D.

Pensacola, Fla.

SCRANTON, PA., March 1, 1915.

Dr. Graham E. Henson,

Secretary Florida Medical Association,
Jacksonville, Fla.

DEAR SIR:

As you may know this committee has worked on the question of reducing the

mortality from cancer since its appointment five years ago. Our work has been directed to educating the laity and also improving the attitude of the medical profession with a view to obtaining more frequent early diagnosis, prompt treatment, and hence fewer deaths. From our work in the past five years we have felt that much the most important thing to do at the present time is to improve the attitude of the medical profession itself. Figures that we recently collected in Pennsylvania show that in this state the physician has his cancer cases under observation for an average period of over one year before radical treatment is begun.

In order to increase the interest of the medical profession we are now working on a plan by which a large number of the medical journals will print a large number of cancer articles and have strong editorials on this campaign, and furthermore the journals that take part are contributing a full page advertisement drawing further attention to this matter. Of course, our own activities are properly confined only to this state, but it has seemed to us that it is quite an opportune time to ask other states to take part in this present cancer campaign. We are arranging for all the county societies in your state and urge them also to have special cancer meetings or special symposiums during the month of June. I am sure that many of the counties would be glad to join in on receipt of a proper letter from you.

In our own state we have found that it often adds a great deal to the interest in smaller counties to have the state society get some prominent member in a larger city to go to the smaller county and give a special address on cancer.

We feel that this is a very valuable opportunity for the organized medical profession to attack a disease which at present kills about 75,000 of our people each year and we feel that cancer meetings all over this country in June to be followed by a flood of cancer literature in July will have a very valuable and lasting effect. We believe that

this movement will be considered a great credit to the organized medical profession and American Medical Journalism. We hope very much, therefore, that you will join in making this a national campaign and urge your counties to devote one of their June meetings to cancer.

Yours very truly,

The Commission on Cancer of the Medical
Society of the State of Pennsylvania,

J. M. WAINWRIGHT,
Chairman.

PROPAGANDA FOR REFORM.

ANALUTOS.—Analutos is a name applied to calcium acetylsalicylate. The Council on Pharmacy and Chemistry refused recognition to Analutos because it was held not to have any advantages over acetylsalicylic acid. In view of this, it was held that medicine should not be burdened with this non-descriptive name. (*Jour. A. M. A.*, Feb. 20, 1915, p. 684.)

BUDWELL'S EMULSION.—Budwell's Emulsion No. 1 is stated to contain cod liver oil, "Iodide of Arsenic," "Iodide of Calcium" and "Iodide of Manganese." Budwell's Emulsion No. 2 is claimed to contain the ingredients of the first and also creosote carbonate and guaiacol. The Council on Pharmacy and Chemistry refused recognition to these preparations because the exploitation made likely their use as "consumption cures" and because they are irrational shot-gun mixtures. (*Jour. A. M. A.*, Feb. 20, 1915, p. 684.)

CELERINA, ALETRIS CORDIAL AND KENNEDY'S PINUS, CANADENSIS, LIGHT AND DARK.—As glaring instances of nostrums exploited to physicians on unscientific claims and false representations, the Council on Pharmacy and Chemistry has prepared reports on the products of the Rio Chemical Co., namely, Celerina, Aletris Cordial, Kennedy's Pinus Canadensis, Light or Abican,

and Kennedy's Pinus Canadensis, Dark or Darpin.

In addition to 42 per cent of alcohol Celerina is stated to contain kola, viburnum, celery, cypripedium, xanthoxylum and aromatics. There is no ingredient in Celerina, except the alcohol, that has any recognizable activity and the alcohol content is nearly as great as that of whiskey. The sooner it is realized that this preparation is essentially nothing but alcohol and bitters exploited under a fancy name, the better for the science of medicine and the public health.

In addition to 28 per cent of alcohol, Aletris Cordial is stated to contain aletris, helonias and scrophularia. These drugs have been discarded as valueless by modern scientific medicine. In Aletris Cordial there is no ingredient capable of producing any other effect than the alcohol stimulation and such psychic effect as may be due to the bitter taste. Yet physicians are asked to believe that "probably no remedy is so uniformly successful in the prevention of threatened miscarriage as Aletris Cordial, Rio." Alcohol being the essential constituent of Aletris Cordial and the amount being high enough to promote the formation of the alcohol habit, the recommendation to administer it during pregnancy and to young girls is dangerous and an outrage.

Kennedy's Pinus Canadensis, Dark, recently renamed "Darpin," and Kennedy's Pinus Canadensis, Light, recently renamed "Abican," are of interest chiefly because of the unwarranted claims which are made for them. The "dark" preparation appears to be some sort of a tannin-bearing extract. The "light" preparation appears to be a sulphate of zinc-alum injection. It is devoid of tannin and is not an extract of pinus canadensis as claimed. A discussion of the claims made for these preparations is superfluous. It is enough to mention that they

are recommended in such diseases as albuminuria, fetid perspiration, gonorrhea, uterine hemorrhage and leucorrhea. (*Jour. A. M. A.*, Feb. 13, 1915, p. 606.)

CITARIN.—Citarin was admitted to New and Nonofficial Remedies in 1906. The Council on Pharmacy and Chemistry held that experience had failed to demonstrate the value of Citarin as a uric acid solvent and hence directed the omission of it from New and Nonofficial Remedies. (*Jour. A. M. A.*, Feb. 20, 1915, p. 685.)

COD LIVER OIL VERSUS MILK, BUTTER AND EGGS.—Like other fats, cod liver oil is readily digested and utilized in the body. Its disagreeable taste has largely outweighed its availability as a nutrient. Recent experiments have established that the peculiar growth promoting qualities of cod liver oil are likewise possessed by butter and egg-yolk fat. There seems to be no reason, therefore, to administer the unpalatable cod liver. (*Jour. A. M. A.*, Feb. 20, 1915, p. 667.)

COD LIVER OIL CORDIALS.—To determine if the growth promoting principle of cod liver oil is contained in the oilless cod liver oil preparations on the market, feeding experiments have been made with some of these preparations by J. P. Street of the Connecticut Experiment Station. In these experiments it was found that the normal nutrition and growth of rats was not maintained when the fat of a standard ration was replaced by a representative amount of Hagee's Cordial of the Extract of Cod Liver Oil Compound, Vinol, Wampole's Perfected and Tasteless Preparation of an Extract of Cod Liver and Waterbury's Compound, Plain. When, then, these animals were placed on a ration containing an equivalent amount of cod liver oil, normal nutrition and growth was soon established. (*Jour. A. M. A.*, Feb. 20, 1915, p. 638.)

PURITY OF ETHER AND POSTANESTHETIC GLYCOSURIA.—Animal experiments by Ross and Hawk show that postanesthetic glycos-

uria is not due to impurities as has been claimed, but is brought about by a carbohydrate free diet prior to the anesthesia. Those who claim that the U. S. P. tests for the purity of ether are insufficient, should present better evidence than they have so far done. (*Jour. A. M. A.*, Feb. 20, 1915, p. 668.)

SALESTHYL AND SAL-HYL.—Salesthyll, a liquid marketed in capsule is stated to be the menthyl ester or methyl salicylate. Sal-Hyl is stated to be an ointment of Salesthyll, but the exact composition is not disclosed. Salesthyll was submitted to the Council on Pharmacy and Chemistry with the claim that it had the properties of salicylates but to be more efficient. The evidence to substantiate the therapeutic claims was found to be inconclusive and untrustworthy. Being similar to "sal-ethyl," described in N. N. R., the name Salesthyll was held objectionable. The Council refused recognition to these preparations. (*Jour. A. M. A.*, Feb. 20, 1915, p. 684.)

TRI-IODIDES, THREE CHLORIDES AND MAIZO-LITHIUM.—As an illustration of unreliability of claims and unscientific character of proprietary mixtures the Council on Pharmacy and Chemistry published reports on Tri-Iodides, Three Chlorides and Maizo-Lithium, products of the Henry Pharmacal Company (J. F. Ballard, proprietor).

The A. M. A. Chemical Laboratory reported to the Council that contradictory and false claims were made in regard to the composition of Tri-Iodides (Henry). The Council held that Tri-Iodides conflicted with its rules in that the composition was incorrectly stated, because it was advertised indirectly to the public, because unwarranted therapeutic claims were made for it, because the name did not indicate the potent ingredients and because the mixture was unscientific.

Three Chlorides was claimed to contain mercuric chloride, arsenic chloride and

ferrous chloride (protochloride of iron). The A. M. A. Chemical Laboratory reported to the Council that, while the advertising matter laid much stress on the superiority of the protochloride of iron which was stated to be present, the iron was not in the ferrous but in the ferric condition. The Council held Three Chlorides in conflict with its rules in that its composition was not correctly stated, in that it was advertised indirectly to the public for the treatment of diseases with the likelihood of doing harm, in that exaggerated and unwarranted therapeutic claims were made for the preparation, in that the name of this mixture did not indicate the presence of its potent constituents: iron, mercury and arsenic, and in that the routine administration of mercury and arsenic with iron in fixed combination is irrational.

Maizo-Lithium is one of the many proprietary lithium preparations based on the disproved theory that lithium dissolves uric acid deposits in the body. While claimed to contain "maizenate of lithium" the Association's chemists reported to the Council that they questioned the existence of such a compound, that the manufacturer had failed to submit evidence of its presence in his preparation and that chemical analysis indicated the presence of lithium citrate, instead. The Council held Maizo-Lithium in conflict with its rules in that its composition was not disclosed, in that it was advertised indirectly to the public and in that unwarranted therapeutic claims were made for it. (*Jour. A. M. A.*, Feb. 5, 1915, p. 528.)

STOMACH BITTERS.—Experiments conducted by A. J. Carlson and his co-workers at the University of Chicago show that the wide-spread use of bitter drugs as a means of stimulating the appetite or aiding digestion is a therapeutic fallacy. He finds that such drugs as gentian, quassia, calumba, hops, condurango and the elixir of quinine, strychnin, and iron do not increase hunger contractions of the stomach and the related

phenomenon nor induce increased secretion of hydrochloric acid or pepsin. (*Jour. A. M. A.*, Jan. 2, 1915, p. 58.)

TOWNS' EPILEPSY TREATMENT.—This is a bromid mixture marketed by the Towns' Remedy Company, Milwaukee, Wis. It was found by the A. M. A. Chemical Laboratory to contain the equivalent of 21.3 grs. of potassium bromid and 0.78 gr. of potassium iodid per dose (one and one-half teaspoonful). (*Jour. A. M. A.*, Feb. 20, 1915, p. 683.)

VIROL.—The Council on Pharmacy and Chemistry voted to refuse recognition to Virol (sold by the Etna Chemical Co. in the United States) because the claims made for it were unsubstantiated and unwarranted. A referee who analyzed Virol concluded that it was an extract of malt, with fat and a small amount of protein. He held that Virol could not be considered a "complete food" as claimed, nor an ideal food for infants. (*Jour. A. M. A.*, Feb. 20, 1915, p. 683.)

VENARSEN.—Venarsen, marketed by the Intravenous Products Co., for the treatment of syphilis, pellagra, tuberculosis, anemia, etc., is a secret preparation. One circular suggests that Venarsen is a sort of an improved salvarsan, but in reality it gives no clew whatever as to the real character of the preparation. Another circular suggests that Venarsen is a shot-gun combination containing arsenic, mercury and other anti-syphilitic drugs. It is not only the right but the duty of physicians to know the essential composition of what they prescribe; a physician who uses a remedy the composition of which is kept secret, even in part, is not doing his duty to his profession nor to his patient. It is almost criminal for physicians to use a preparation of secret composition and to administer it by intravenous injection—a method which in itself is altogether likely to give rise to accidents. (*Mo. State Med. Jour.*, Jan., 1915.)

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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Second District—Franklin, Gadsden, Jefferson, Leon, Liberty and Waukulla Counties: Henry E. Palmer, M. D., Tallahassee 1917

Third District—Columbia, Hamilton, Madison, Lafayette, Suwanee and Taylor Counties: C. S. Brown, M. D., Live Oak 1917

Fourth District—Duval, Clay, Nassau and St. Johns Counties: Gerry R. Holden, M. D., Jacksonville. 1918

Fifth District—Citrus, Hernando, Lake, Marion and Sumter Counties: H. C. Dozier, M. D., Ocala. 1915

Sixth District—Hillsborough, Pasco and Pinellas Counties: U. S. Bird, M. D., Tampa. 1915

Seventh District—Brevard, Orange, Osceola, St. Lucie and Volusia Counties: David Forster, M. D., Hawks Park P. O., New Smyrna. 1918

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Ninth District—Calhoun, Holmes, Jackson and Washington Counties: J. S. McGeachy, M. D., Chipley, 1918

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Eleventh District—Dade, Monroe and Palm Beach Counties: W. R. Warren, M. D., Key West. 1917

Next Meeting—DeLand—May 12-14, 1915

THE DeLAND MEETING.

The forty-second annual meeting of the Florida Medical Association will convene in DeLand on May 12th and will remain in session until the 14th. Many matters of importance to the Association will be brought before the House of Delegates, making it especially desirable that each county send its full representation.

The Committee on Scientific Work, under the chairmanship of Dr. Ralph Greene, of Chattahoochee, have prepared a program that will eclipse those of all previous meetings.

The local profession in Volusia county are busily engaged in making plans for the entertainment of the members of the Association. Let us have a full representation of the profession from all sections of the State. On to DeLand.

SUGGESTED LEGISLATION.

The following proposed bills were presented for discussion, approved, and their passage urged on the different States, at the eleventh annual conference of the American Medical Association on Public Health and Medical Legislation:

"A Bill for an Act Entitled an Act for the Prevention of Blindness from Ophthalmia Neonatorum; Defining Ophthalmia Neonatorum; Designating Certain Powers and Duties and Otherwise Providing for the Enforcement of This Act.

SECTION 1. OPHTHALMIA NEONATORUM DEFINED.—Any diseased condition of the eye, or eyes, of any infant shall, independent of the nature of the infection, be known as ophthalmia neonatorum, in which there is any inflammation, swelling or redness in either one or both eyes of any such infant, either apart from or together with, any unnatural discharge from the eye, or eyes, of any such infant at any time within two weeks after the birth of such infant.

SEC. 2. DUTIES OF PHYSICIANS, MIDWIVES, REPORTING, ETC.—It shall be the duty of any physician, surgeon, obstetrician, midwife, nurse, maternity home or hospital of

any nature, parent, relative, and any person or persons assisting in any way whatsoever, any woman at childbirth, or assisting in any way whatsoever any infant, or the mother of any infant, at any time within two weeks after childbirth, observing or having a reasonable opportunity to observe the condition hereinabove defined, and within six hours thereafter, to report such fact, as the State Board of Health shall direct, to the local health officer of the city, town, village, or whatever other political division there may be, within which the mother of any such infant may reside: Provided that this section shall be construed to impose upon parents, relatives, guardians and the like the further duty to report pursuant to this law, should the physician and the like fail to report as hereinabove and hereinafter enacted.

SEC. 3. DUTIES OF MATERNITY HOMES, RECORDING; PHYSICIANS, PRESCRIBING, ETC.—It shall be the duty of all maternity homes and any and all hospitals, etc., to maintain such records of cases of ophthalmia neonatorum as the State Board of Health shall direct. It shall be the duty of any and all physicians, midwives, and the like, in addition to reporting as hereinbefore enacted, to advise, prescribe and employ, in the treatment of all cases of ophthalmia neonatorum, such prophylactic as the State Board of Health shall direct; and to inform the parents or guardians of a child as to the dangers and dire consequences of this disease by furnishing and distributing to them copies of this law together with such advice and information as the board of health shall direct: Provided that this shall not be construed as a performance of the duties devolving upon the Board of Health as hereinafter set forth in Section 5, Parts 2 (c), and 4.

SEC. 4. DUTIES OF THE LOCAL HEALTH OFFICER.—It shall be the duty of the local health officer:

1. To investigate each case as filed with him in pursuance with this law, and any other such case as may come to his attention.

2. To report all cases of ophthalmia neonatorum and the results of all such investigations as he shall make, as the State Board of Health shall direct.

3. To conform to such other rules and regulations as the State Board of Health shall promulgate for his further guidance, and for the enforcement of this law.

SEC. 5. DUTIES OF THE STATE BOARD OF HEALTH.—It shall be the duty of the State Board of Health:

1. To enforce the provisions of this act.

2. To promulgate such rules and regulations as shall, under this act, be necessary: (a) for the purpose of this act generally; (b) for the further and proper guidance of local health officers in the administration of this law; (c) for the distribution of copies of this law together with information and advice to physicians, etc., and the public generally for their education, etc.

3. To provide for the gratuitous distribution of a scientific prophylactic for ophthalmia neonatorum, together with proper directions for the use and administration thereof, to all physicians, midwives and the like; and to provide gratuitous treatment in all such cases in which poverty would prevent securing a proper and efficient physician, surgeon or obstetrician.

4. To print, publish and distribute to all heads of families or guardians, personally, throughout the State, advice and information concerning the dangers of ophthalmia neonatorum and the necessity for the prompt and effective treatment thereof, together with copies of this law.

5. To furnish similar advice and information together with copies of this law to all physicians, midwives and the like, throughout the State.

6. To keep a proper record of any and all cases of ophthalmia neonatorum as shall be filed in their office in pursuance with this law, and as may come to their attention in any way, and to constitute such records a part of the annual report to the governor and the legislature.

7. To report any and all violations of this act as may come to their attention in any way whatsoever to the prosecuting attorney of the district wherein said misdemeanor may have been committed, and to assist said official in any way possible, such as by securing necessary evidence, etc.

SEC. 6. VIOLATION OF ACT A MISDEMEANOR.—The failure of any and all physicians, midwives, etc., as hereinabove set forth, to report as herein prescribed, or the failure of any hospital to record, as hereinbefore enacted, or the failure of any physician, midwife and the like, to treat as the State Board of Health shall have directed, any and all cases of ophthalmia neonatorum, as herein prescribed, and, under such circumstances as are herewith set forth, or any or all of such violations, or any violation of this act whatsoever, as the case may be, shall constitute a misdemeanor under this act.

SEC. 7. COLLUSION A MISDEMEANOR.—Any collusion between any official and any person, or between any others herein named, to misstate or conceal any facts which under this act are essential to report correctly, etc., shall likewise constitute a misdemeanor, and the accused shall, upon conviction, suffer a penalty such as is hereinafter enacted.

SEC. 8. BURDEN OF PROOF PROSECUTION.—Any and all cases of ophthalmia neonatorum, or the resultant blindness therefrom, in which the accused may have been one of the persons, or class, or classes of persons, as hereinabove set forth in Section 2, whose duty it was to report, etc., as hereinbefore set forth, shall be taken as prima facie evidence of guilt on the part of the accused. It shall be the duty of the State's attorney, for the proper district, to prosecute for all misdemeanors as herein prescribed.

SEC. 9. JUDGES OF THE LAW AND FACT.—For the purposes of this act the court shall be judge of the law while the jury shall be constituted judges of the facts only.

SEC. 10. PENALTY.—Any person accused of a misdemeanor under this act shall, upon conviction thereof, be fined, for the first

offense, not to exceed \$50.00; for the second offense, not to exceed \$100.00, and for a third offense, and thereafter, not to exceed \$200.00 for each violation.

SEC. 11. APPROPRIATION.—The sum of \$. shall be annually appropriated for the use of the State Board of Health in enforcing and carrying out the provisions of this act. Any and all necessary and legitimate expenses that may be incurred in prosecuting a case under this act shall, upon a proper showing, be met by the State Board of Health out of this appropriation.

SEC. 12. EMERGENCY.—An emergency existing, this act shall take effect upon its passage as by law prescribed.

SEC. 13. REPEALING.—All acts and parts of acts in conflict herewith are hereby repealed."

"An Act Providing a Method for Obtaining and Presenting in Court Evidence Regarding the Insanity of the Defendant in Criminal Cases.

SECTION 1. SUMMONING OF WITNESSES BY COURT.—Whenever in the trial of a criminal case the issue of insanity on the part of the defendant is raised, the judge of the trial court may summon one or more disinterested qualified experts, not exceeding three, to testify at the trial. In case the judge shall issue the summons before the trial is begun, he shall notify counsel for the prosecution and defence of the witnesses so summoned. Upon the trial of the case, the witnesses summoned by the court may be cross-examined by counsel for the prosecution and defence. Such summoning of witnesses by the court shall not preclude the prosecution or defence from using other expert witnesses at the trial. The witnesses summoned by the judge shall be allowed such fees as in the discretion of the judge seem just and reasonable, having regard to the services performed by the witnesses. The fees so allowed shall be paid by the county where the indictment was found.

SEC. 2. EXAMINATION OF ACCUSED BY STATE'S WITNESS.—In criminal cases, no testimony regarding the insanity of the defendant shall be received from witnesses summoned by the defendant until the expert witnesses summoned by the prosecution have been given an opportunity to examine the defendant.

SEC. 3. COMMITMENT TO HOSPITAL FOR OBSERVATION.—If in a criminal case the issue is raised that the defendant is insane, so that he ought not to be tried, the judge of the trial court shall commit the defendant to a state hospital for the insane, preferably the one nearest the place of trial, to be detained there for purposes of observation until further order of court, provided that the duration of such detention shall not exceed three months. The court shall direct the superintendent of the hospital to permit all the expert witnesses summoned in the case to have free access to the defendant for purposes of observation. The court may also direct the chief physician of the hospital to prepare a report regarding the mental condition of the defendant. This report may be read at the trial of the issue of insanity by the said chief physician after he has been properly sworn as a witness. After reading the report the witness may be cross-examined by counsel for the prosecution and defence.

SEC. 4. WRITTEN REPORT BY WITNESSES.—When the issue of insanity has been raised in a criminal case each expert witness, who has examined or observed the defendant, may prepare a written report, based upon his examination or observation, regarding the mental condition of the defendant, and such report may be read by the witness at the trial. If the witness presenting the report was called by the prosecution or defence, he may be cross-examined regarding his report by counsel for the other party. If the witness was summoned by the court, he may be cross-examined regarding his report by counsel for the prosecution or defence.

SEC. 5. JOINT REPORT BY WITNESSES.—Wherever in a criminal case expert witnesses have examined or observed the defendant, on whose behalf the issue of insanity has been raised, they may consult before testifying, and may prepare a joint report regarding the mental condition of the defendant. This report may be read at the trial by one of the experts who joined in the report, after all the experts who joined in the report have been duly sworn as witnesses. All the experts who joined in the report shall be subject to cross-examination by counsel for the prosecution and defence."

MEDICAL DEFENSE FUND.

The following is a copy of the By-Law which the Volusia County Medical Society intends to present for discussion before the House of Delegates at the coming meeting of the State Association to be held at Deland. The bill was discussed under the "County Society News" from Volusia county, in the March number of *The Journal*. It is a matter of considerable importance and one that should receive the careful attention of each member of the association:

"SECTION 1. At the end of each year, the sum of fifty cents for each member shall be set aside by the Treasurer, as a special fund, to be called the Medical Defense Fund. This fund shall be kept separate from other moneys in this Society and may be invested by the Treasurer under the direction of the Council, and shall be used only for the legal expenses of members threatened with, or prosecuted for, alleged malpractice.

SECTION 2. The Council shall select a member of the Bar of Florida as Legal Counsel of the Society, and is empowered to pay such counsel an annual retaining fee. To the Legal Counsel shall be submitted all suits for alleged malpractice brought against members of this Society and he shall be asked to endorse local counsel suggested or engaged by the Councilor to defend such

suits. To him also shall all proposed appeals to higher courts be submitted. The proper fees for defending members of this Society in suit for alleged malpractice shall be paid out of the Medical Defense Fund, provided that the member has placed his case in the hands of this Society in accordance with the regulations adopted by the Council and approved by this Society.

REGULATIONS GOVERNING THE MEDICAL DEFENSE FUND.

1. A member sued or threatened with suit for alleged malpractice should at once fill out the application blank which can be secured either from the secretary of his county medical society, from the Secretary of the State Medical Society or from the Councilor for the district. The Society will not undertake the defense of any member unless his application is made within thirty days after service of summons.

2. The application must be endorsed by unanimous vote of all the censors of his county society present at a special meeting called for this purpose, after a rigid examination of all of the facts in the case, not only as regards the applicant's membership and standing in his society but also as regards the worthiness of the applicant's case. It should be understood that the endorsement of the censors of a county society carries with it not only moral support, but their active participation in the conduct of the trial in any way they may best assist, and all without thought of pecuniary return.

3. As soon as the application has received the endorsement of the censors of the county society, it should be sent to the Councilor of the district for his endorsement. The Society will not be responsible for attorney fees incurred in the defense of any member, the defense of whom has not been approved by the Councilor for the district.

4. After the application has received the endorsement of the county society censors and the Councilor for the district, the management of the member's defense will rest with a committee of the Council con-

sisting of the Councilor for the district, the President and the Secretary of the State Society.

5. The applicant should sign a contract vesting in the Committee of Council sole authority to conduct the defense of his suit, and he should agree to make no compromise or settlement of the case without the consent of the Councilor of his district given in writing.

6. The State Society will not undertake the defense of any member who after investigation by the censors and Councilor for the district is believed guilty of criminal abortion, feticide, homicide or any criminal act or who has not conformed to the recognized ethical laws in regard to these cases. It will only defend suit brought in the course of legitimate professional work.

7. The State Society will not pay any expenses for serving subpoenas nor the expense of witnesses residing within the county, nor will it pay judgment or fine awarded or imposed by the jury or court.

8. It should be understood by the members of the State Medical Society that the amount in the Medical Defense Fund is not large, and in all probability, it will be years before this fund will provide unlimited resources for defense of suits against members. Consequently this fund should be conserved by every effort on the part of the membership of this Society."

MEDICAL JOURNAL ADVERTISING.

Why should State medical journals devote so much attention to advertisements?

There are several reasons. First, and probably more important, advertisements make possible first-class, well-printed, attractive journals. They furnish the sinews of war. In most State medical journals the advertising furnishes fifty per cent of the necessary revenue. If there were no advertisements, your monthly journal would cost you twice as much.

And another point, advertisements are news; if the advertising is carefully censored,

as it is in all first-class, honest journals, the advertising pages contain announcements of real interest to men of every field of practice. This is particularly true of the publishers' announcements. The sanitarium and institutional advertising likewise affords handy reference pages for the busy general practitioner.

Advertisements have an important bearing upon raising what might be termed the mechanics of medical practice. A doctor, for instance, sees the announcement of a firm offering a device for the systematic care of his accounts. He buys it. He finds it a material aid. Patients are better satisfied and his collections are better. Had the matter not been brought to his attention through the advertisement he would probably have worried along with his former haphazard methods. In like manner the constant advertising of the electrical supply companies has extended the use of the X-ray and similar equipment which is valuable. Many other instances might be cited.

Advertising, therefore, is valuable to the journal and valuable to the reader. Read the advertisements in *your* journal. And, everything else being equal, patronize the firms which patronize it. They furnish you the journal at one-half price, and if the journal is "on the square," they are, and they frequently offer suggestions which you may adopt with profit.—*The Ohio State Medical Journal*.

THE PHYSICIAN AND THE HARRISON NARCOTIC LAW.

"From the large number of inquiries received," says *The Journal of the American Medical Association*, "it is evident that many physicians are in doubt as to what they are required to do under the Harrison law and what the law will do to them. So many misstatements on this subject have appeared that a brief summary of the purposes and requirements of the law may be reassuring.

"The law affects the physician both as a prescriber and as a dispenser of drugs. The only effect it has on the former—the pre-

scribing physician—is that it requires him to register with the collector of internal revenue of the district, and that in writing a prescription for narcotic or habit-forming drugs he must write the name and address of the patient, have on the prescription his office address and his registry number, and sign his name in full. He can—and should, probably, if he has printed blanks—have his registry number printed on the blank. He does not have to keep copies of prescriptions; this is done by the druggist. These prescriptions cannot be refilled. This is all there is to the Harrison narcotic law so far as it affects the prescribing physician. The only expense is in securing his license once a year, at a cost of \$1. And the only facts to be kept in mind in writing prescriptions are that the patient's name and address must be written thereon and that the physician must sign his name in full—precautions, however, that should be taken on all prescriptions.

"If the physician desires any of the specified drugs for his own use, he must then make out an order for them on a blank form bearing his registry number. These blanks are furnished by the Internal Revenue Department in packages of ten for 10 cents. The physician cannot order drugs for his own use on a prescription blank.

"If a physician is in personal attendance on a patient, he can administer any treatment he sees fit in the form of hypodermic injection, sprays, applications, etc. If he orders a nurse to give such treatment, then the written order must appear in the history sheet with the physician's initials. The statement recently appeared in a druggists' journal that an official ruling had discriminated between a visit to the patient at his home and personal treatment of a patient by a physician at his office, and that one was personal attendance and the other was not. This statement is without foundation. No such ruling has been made.

"If a physician dispenses his own drugs, then he must conform to the same restrictions as a druggist. He must order the

drugs specified by this law on the blanks furnished by the internal revenue collector, and he must keep a record of the dispensing of such drugs, the date, the quantity and the name and address of the person to whom they were given. This record must be kept in a 'suitable blank book,' and must be preserved for two years. Drugs dispensed while the physician is in personal attendance on the patient do not need to be recorded. Neither do preparations which do not contain more than 2 grains of opium, one-fourth grain of morphin, one-eighth grain of heroin or 1 grain of codein.

"These provisions are simple and need cause the physician little annoyance. The great majority of physicians write prescriptions. Physicians who dispense preparations of narcotic drugs do so only occasionally. The restrictions for both classes are simple and easily observed. The cost for all physicians is the same, a nominal fee for registration, a small cost for order blanks. Additional rules may be found necessary as the law is enforced, but there is at present nothing that need cause physicians any inconvenience or annoyance.

"But what about old habitues, persons suffering from painful and incurable diseases, and others to whom opium in some form is absolutely necessary? Every physician knows of such cases. For them the physician so long as he complies with the law of his own state can prescribe whatever he sees fit. But it must be done openly and without attempt at evasion, and the physician must be ready and able at any time to justify his acts. The whole purpose of the law is to restrict the use of opium and cocain to legitimate channels."

WINE OF CARDUI ACTIVITIES.

"Turning the light into the noisome pit of charlatanry always stires into squirming activity those who subsist, either as hosts or parasites, on such business. For nostrum exploiters champion that comfortable doctrine, 'Let Us Alone'; they inscribe as their

heraldic motto: *Laissez-faire*. To the public unacquainted with *The Journal's* educational campaign of the past decade," says *The Journal of the American Medical Association* for Feb. 27th, "it might appear that the exposure of the fraud connected with the exploitation of Wine of Cardui was a veritable crusade into a new field. During the past few months it has been necessary, almost daily, to assure interested laymen that the Wine of Cardui articles were but incidents in *The Journal's* general propaganda of education relative to medical frauds. The amount of 'fuss and feathers' displayed in this specific case is due to several causes—remote and proximate. The most important, probably, is the fact that the chief owner of the Wine of Cardui business is one of the most prominent and powerful laymen in the Methodist Church. Of almost equal importance is the fact that the Wine of Cardui business has been, and still is, enormously profitable. Then there is the incidental fact, that the growing spread of prohibition that threatens the millions invested in the distillation of alcohol makes the fate of 'patent medicines' of the alcoholic-tonic type—a business not as yet legally affected by prohibitory laws—one of tender solicitude to the distillers. Add to these reasons the further one that the nostrum evil is, today, before the bar of public opinion, and it is easy to realize that the Wine of Cardui suits against the American Medical Association and the editor of *The Journal* are causing a stir such as inevitably follows the lavish expenditure of large sums of money.

"An interesting story could be written of some curious coincidences that have occurred since the Chattanooga Medicine Company and its chief owner brought their suits. Articles appearing in the mouthpieces of the 'patent-medicine' interests warning the public against the fell designs of the 'Medical Trust' have been reprinted and widely circulated; nostrum-championing editorials of the 'canned' variety have cropped out in the newspapers that may always be counted on

to come to the defense of the 'patent-medicine' business; decoy letters have come to *The Journal* office from hypothetical 'doctors,' mailed from postoffice addresses in villages in which the writers apparently rented a postoffice box and to which they went in motor cars to get the 'answers' that never came; detectives have posed as journalists seeking information about nostrums of the alcoholic-tonic type and have played the part of visitors to Chattanooga, solicitous (?) of the well-being of the new church organized after the split in the First Methodist Church of that city following the Wine of Cardui exposures; attempts have been made to 'work' stenographers; efforts have been put forth to learn in advance the dates of public talks to be given on the nostrum evil under the auspices of *The Journal*—these are but a few of the many things that have occurred. Whether any of these occurrences bear any relation to the Wine of Cardui suits or are wholly or partly inspired by the general 'patent-medicine' interests, or whether they are simple coincidences, we leave for our readers to decide.

"But to the medical profession the following synopsis of events will probably be of more interest than the trivial details of the 'ways and means' of the nostrum interests in defendin g its unwholesome brood:

"1 a: The Journal publishes an article July 18, 1914, showing the fraud connected with the exploitation of Wine of Cardui.

"b: Suit brought by the Chattanooga Medicine Company and J. A. Patten for \$300,000 against the American Medical Association and the editor of *The Journal*.

"c: *The Journal* publishes a second article December 5, 1914, on the same subject.

"2 a: Dr. Oscar Dowling, one of the trustees of the American Medical Association, in his capacity as President of the State Board of Health of Louisiana, accompanies the State Health Train from New Orleans to Richmond, Va. The train carries among its health exhibits exposures of various nostrums, including a card dealing with

Wine of Cardui. A stop is made at Chattanooga.

"b: Dr. Dowling is sued by the Chattanooga Medicine Company for \$25,000, the papers being served on him before he left Chattanooga.

"c: State Board of Health of Louisiana meets and upholds Dr. Dowling, and declares Wine of Cardui a fraud.

"3 a: The Limestone County (Ala.) Medical Society passes resolutions condemning the methods of the Chattanooga Medicine Company in soliciting physicians to testify for Wine of Cardui.

"b: The Chattanooga Medicine Company sends legal representatives to Limestone County intimating that both the society and the individuals comprising it would be sued if the resolutions are not rescinded.

"c: The Limestone County Medical Society 'stands pat.'

"4 a: The Chicago City Club gives a Public Health Exhibition and among other exhibits has the American Medical Association educational posters on medical frauds. Wine of Cardui cards among them.

"b: Local legal representative of Chattanooga Medicine Company attempts to bluff City Club into removing the Wine of Cardui posters.

"c: Bluff 'called.' Nothing happens.

"5 a: *Harper's Weekly*, in its series on fraudulent 'patent medicines,' gives some space to Wine of Cardui and its manufacturers.

"b: *Harper's Weekly* sued for \$200,000 by Chattanooga Medicine Company.

"c: *Harper's* 'comes back' in its issue of February 27th."

HEALTH BOARDS AND THE TAX-PAYER.

"Appropriations for health purposes in many communities have in the past been granted reluctantly, and in most instances in insufficient amounts for effective work. It has been difficult to convince the taxpayer and the public official that there would

be an adequate return for money expended. Health to them has seemed an individual matter," says *The Journal of the American Medical Association*, "and health boards have been compelled to beg for every dollar. An improvement, however, is taking place, and the amount per capita of health appropriations is increasing. A more intelligent understanding of the objects of public health expenditures and of the returns to be had is developing. In some instances, the taxpayer is now on the other side of the proposition. He demands of the health board, having approved liberal appropriations, that it prevent epidemics which endanger the health and lives of himself, his family and his friends. Spartanburg, S. C., has been for several years a center for the study of pellagra by a scientific commission. This has no doubt promoted the study of health matters in general in that community, with the result that the local health service has been well supported, while the people have come to recognize the possibilities of disease prevention. With the idea in mind of the seasonal recurrence of certain infectious diseases, the Spartanburg *Herald* says:

"For the amount of money the citizens of Spartanburg are putting up these days for the public health department they have reason to expect service and results. * * * Just at this season of the year and a little later on, in February and March, most cities are visited by * * * scattering cases of diphtheria and epidemics of measles and whooping-cough. Measles and whooping-cough usually spread until they have exhausted the supply of youngsters who have come on since the last year's epidemic, while diphtheria, because of its more violent character, is usually held in check. But the question in our mind is whether these things have to be. In modern days is there no way to prevent so much suffering and sickness on the part of the little children of a city? The Spartanburg health authorities could

in no way carry their services nearer the homes of the people than by making a study of this question and taking every precaution possible to hold these things in check this year.'

"It goes without saying that the health board of Spartanburg will do its utmost, but this change of attitude of the taxpayer toward disease prevention is interesting and hopeful. It also emphasizes the obligation on the part of health departments to make good."

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Discuss medical matters of interest.

Obituary

RICHARD P. DANIEL, M. D. **of Jacksonville**

Doctor Richard P. Daniel of Jacksonville died on April 10th after a long illness. The news of his death while not unexpected came as a shock to his hundreds of friends in the city of Jacksonville and throughout the State. In the passing of this noble character the medical profession of Florida loses one who will be sadly missed, not only by the older members of the profession, with whom for so many years he was closely associated, but also by the younger ones. In spite of advanced years Doctor Daniels kept up with the advances of modern medicines to a remarkable degree. Of a kindly disposition and endowed with a genial nature, he was loved by all who were honored with his friendship.

Doctor Daniels was born in South Carolina on August 19, 1828, and was a resident of Jacksonville for nearly seventy years. Receiving the degree of Doctor of Medicine from the University of Pennsylvania in 1854 he entered the United States Navy and as assistant surgeon was attached to the San Jacinto. He remained in the service for five years, during which time he cruised around the world. He returned to Florida shortly before the Civil War and at the opening of hostilities offered his services and was attached as surgeon to the Eighth Florida Regiment. He served during the entire war and was with Lee's army at the surrender of Appomattox.

He again returned to Florida and resumed the practice of his profession in Jacksonville, enjoying a lucrative practice in this city for over sixty years.

Doctor Daniels was honored with many positions of trust, being the first President of the State Board of Health. He served as President of both the Duval County Medical Society and the Florida Medical Association, of which organizations he was an honored member up to the time of his death. He was also the Chief of Staff of St. Luke's Hospital for many years. *Requiescat in pace.*

Reviews from Current Literature

ACUTE APPENDICITIS.

Smythe, Frank D.: Data Obtained Through Correspondence with Nine Hundred General Practitioners and Surgeons Relative to the Diagnosis, Treatment and Classification of Acute Appendicitis. *Memphis Medical Monthly*, December, 1914.

The writer tabulates in percentages the opinions of eight hundred general practitioners regarding certain points relative to the diagnosis and treatment of acute appendicitis. Sixty-two of these men advise early operation, considering the disease a surgical one; thirty-five per cent of the physicians, as a matter of election, treat the disease in accordance with the so-called expectant plan, but ninety per cent advise operation in cases of acute appendicitis which progress unfavorably after a period of one or more days.

Seventy per cent regard acute appendicitis as strictly a surgical disease from its inception and advise operation as early as possible after the diagnosis is made and urge that it be performed certainly within the first forty-eight hours after the onset. Twenty-nine per cent believe that the disease may be either medical or surgical and state that it is their custom to treat all cases medically in the absence of the development of unfavorable or alarming symptoms, and that in the event of the development of complications operation should be done at once.

One per cent of the men were of the opinion that the disease should be treated by medical measures only, and three per cent advised operation as a last resort. (It would appear that a man who, in this day of absolute knowledge and progressiveness, holds to the opinion that appendicitis is a medical disease only must be at least a half a century behind the times.)

Ninety-nine per cent of the men stated that they were apprehensive in regard to the future safety of their patients who had suffered an attack of appendicitis, for the reason that they believe that all such cases were more or less liable to recurrence with all the risk incident to an infected appendix.

Eleven questions were also submitted to one hundred well-known American surgeons. In reply to the question as to the symptoms upon which a positive diagnosis of appendicitis is made, the following is an example of the general opinion:

a. "Pain, sudden, more or less severe, usually in the epigastrium or umbilical region at the outset, and may or not become general.

b. Nausea, vomiting.

c. Local sensitiveness, which may vary considerably as to degree and location.

d. Elevation of temperature.

e. Leucocytosis.

f. Rigidity of the rectus in region of appendix, may become general early.

g. Increased tenderness upon pressure over the appendix."

Ninety-nine of the surgeons stated that each and every case of uncomplicated appendicitis should be operated upon as soon as possible after diagnosis, and were positive that operation done by a competent surgeon was the safest method of treating the disease.

All of the surgeons believe that no case of appendicitis referred during the early stage of the disease is injured in any way as a result of the trip to the hospital, but that as a rule the patient should not be moved after the disease has reached the stage of diffuse peritonitis.

As to mortality statistics, the surgeons place the mortality of the disease under medical treatment alone at from ten to fifty per cent, the general average being twenty-four per cent for medically treated cases. The mortality of cases operated within the first twenty-four hours is practically nothing; the mortality of cases operated within the forty-eight hour limit varied from one-half of one per cent to ten per cent; the mortality for cases operated at seventy-two hours varied from one and one-half per cent to forty per cent.

"But five of the surgeons stated that they had lost one case each of acute appendicitis operated on within twenty-four hours after onset of symptoms" (not twenty-four hours after diagnosis).

"All the remaining surgeons answered that they had not lost a single case of acute appendicitis operated upon within twenty-four hours after onset of initial symptoms. The record is conspicuous and very interesting, for the reason that not a single death has resulted from operation where the pathology at the time of operation was limited to the appendix. All the cases that succumbed following operation were cases of perforative appendicitis, and were cases of peritonitis, more or less diffuse, and not of uncomplicated acute appendicitis.

"Every surgeon answered in the affirmative that early operation should be urged, and stated that, in their opinion, acute appendicitis being strictly a surgical disease, that the attending physician should not content himself with merely advising operation, which does not give the patient the same opportunity of deciding his or her possible destiny that a physician has, who is intimately acquainted with the facts. One only of the number is of the opinion that the physician has discharged his full duty when he simply advises operation as being the safest method of treatment."

The author summarizes the opinion of the majority of these nine hundred men as follows:

"FIRST—That acute, uncomplicated appendicitis is strictly a surgical disease.

SECOND—That a positive diagnosis of acute, uncomplicated appendicitis can be made by the average clinician within twelve hours after onset of attack, certainly within twenty-four hours.

THIRD—Symptoms sufficient, subjective and objective, to base a diagnosis upon are:

a. Pain, sudden in onset, appearing first in epigastrium, as a rule, may become general, localizing more or less early in the region of the appendix.

- b. Nausea, with or without vomiting.
- c. Elevation of temperature.
- d. Rigidity of right rectus.
- e. Tenderness upon pressure over the appendix.
- f. Leucocytosis.

FOURTH—That since we have no record of deaths resulting from acute appendicitis, uncomplicated, that were operated upon within twenty-four hours after onset of attack, we are justified in assuming that the risk incident to the disease, if operated upon, is practically nil, and that it is our duty to the patient to urge early operation in all such cases.

FIFTH—That a patient suffering with acute appendicitis during the early stage of the disease may be transported to the hospital with perfect safety.

SIXTH—Information from all sources at my command warrant the conclusion that from 8 to 10 per cent of patients suffering with acute appendicitis treated medically die of the disease during the first attack, and that a very large majority of those experiencing relief from the first attack have exacerbations, or so-called recurrent attacks, thus further increasing the death rate of the original attack of appendicitis. Ultimately fifty per cent die or remain more or less ill in consequence of the diseased appendix until operated upon.

SEVENTH—We are justified in promising relief following operation in 100 per cent of cases uncomplicated, during the first twenty-four hours of the disease, with a mortality rate of less than one per cent in cases operated upon during the second day of the attack.

EIGHTH—That the medical attendant should not be held blameless who treats a case of known appendicitis medically, in the event of a fatal issue, where he failed to urge early operation, as operation performed by a capable surgeon is regarded by all authorities as the safest and most successful method of treating the disease."

The remedy offered by the essayist for the removal of the obstacles to a no-death rate in acute appendicitis cases is:

FIRST—That the general practitioner, wherever possible, accompany his cases of acute appendicitis to the surgeon, and witness the operation and carefully examine the pathology after its removal. It would seldom be necessary for the general practitioner to witness more than a very few such operations to convince him that early operation is not only the safest method of treating the disease, but imperatively demanded, in order to protect a given case from disaster, if not death.

SECOND—That the subject of acute appendicitis should be taught in the medical colleges by those teaching in the surgical department only, and that the literature on the subject should be found in text-books on surgery and journals devoted to the publication of articles on surgical subjects, for the reason that acute appendicitis, like fractures of bones and tumors of the breast, is strictly a surgical disease.

THIRD—That a physician has no moral right to subject a patient with acute appendicitis to the hazard of delay by instituting at the outset of an attack medical treatment for a disease that is strictly surgical from its inception, there being no medical treatment for appendicitis, and the cases that die, do so as result of delay in applying the proper remedy.

Evidence from all directions and from all sources is so overwhelming to the effect that no case operated upon by a competent surgeon has died from the disease, when operation was performed at a time when the pathology was limited to the appendix, and evidence from similar sources is to the effect that death very commonly occurs as result of the disease when treated medically, hence we are at a loss to understand how any one could, as a matter of choice, pursue a plan so hazardous as the medical treatment of appendicitis has proven to be when surgical treatment, promptly instituted, has proven almost uniformly safe and successful."

R. C. T.

APPENDICITIS.

Williams, A. W., Maj. Medical Corps, U. S. A.: *Appendicitis Under Field Service Conditions*. N. Y. Med. Jour., Vol. CI, 1915, p. 14.

Major Williams reports an interesting series of fifty-two operations for appendicitis under field service conditions with United States Army troops. Thirty-eight patients were operated on in the field hospital at Texas City, Texas, and fourteen cases in the buildings temporarily occupied by Field Hospital No. 3 at Vera Cruz, Mexico. There was no mortality among the fifty soldiers. Death occurred in one case, that of a civilian who was admitted with a gangrenous appendix of three days' standing. The subjects were mostly young, healthy soldiers averaging twenty-five years of age. The good results are attributed, first to the age and good health of the men and to the fact that they were transferred to the field hospital by the surgeons of their regiments, usually within twelve hours after being taken sick.

The writer states "that at the field hospital we were ready to operate day or night within an hour after a definite diagnosis was made, the teaching of that great teacher and operator, Deaver, that 'delay means disaster' was kept constantly in mind. At the field hospital five medical officers were on duty. Consultants were at hand, and interference by solicitous relatives and friends was not a cause for delay."

The patients were prepared by dry shaving and painting with one-half strength U. S. P. tincture of iodine a half hour before operation, followed by a thorough painting of the area with the same strength iodine solution immediately before operation.

In his summary the author states that under battle conditions the resources of field hospitals are taxed to the limit of their capacity, hence appendicitis and other major cases would necessarily have to be transferred back to the lines of communication or base hospitals for operation, but that in mobilization camps, with the present simplified and efficient methods, major surgery can be done in field hospitals with practically the

same degree of safety as in the more expensive modern operating rooms. R. C. T.

TETANUS.

Kelley, T. H.: Report of Case of Tetanus. J. A. M. A., Vol. LXIV, 1915, p. 815.

The writer reports the cure of a severe case of tetanus by the intraspinal administration of tetanus antitoxin as outlined by Park and later by Irons. The patient, aged eleven, was sent to a hospital fourteen days after having sustained lacerated injuries about the ankle. Stiffness of the jaw and a few slight convulsions were noticed on the ninth and tenth days following the injury. At this time 1,500 units of tetanus antitoxin were given intramuscularly without effect. Upon admission he presented a typical picture with convulsions occurring about every fifteen minutes. He was taken to the operating room and anesthetized with gas and ether. Fifteen hundred units of antitoxin were given by intraspinal route, and 1,500 units given intravenously. The following day another injection of 3,000 units of antitoxin was given intraspinally and 3,000 intravenously, after which recovery was rapid.

"The local treatment consisted in exposing the wound to a continuous stream of oxygen for thirty-six hours with boric acid and alcohol dressings later to counteract the local infection."

During the first two days in hospital morphine and chloroform were used as sedatives at intervals.

The author believes "that in the intraspinal administration of tetanus antitoxin we have an agent that has robbed lockjaw of its despairing terrors." R. C. T.

THE OXYTOMIC EFFECT OF PLACENTAL EXTRACT.

Curtis, Arthur H.: "Experiments in the Production of Abortion and Labor by Use of Placental Extracts." Surg., Gyn. and Obst., March, 1915, Vol. XX, p. 292.

Veit has shown that placental material is present in the circulating blood of pregnant women. Inasmuch as the author found a

suggestion of an oxytomic effect in the injection of whole blood from healthy puerperal cases in patients who failed to go into labor at term, he conceived the suggestion that perhaps the presence of placental elements might be responsible for this. Therefore he made a study of the effect of placental extracts in pregnant rabbits and guinea pigs.

Human placentas were used. An aseptic extract in normal salt solution was used. In twelve out of sixteen experiments an oxytomic effect was produced. Defibrinated blood from pregnant and puerperal women was also tried. It possesses a certain amount of oxytomic effect but to a lesser degree.

Controls were made by using normal salt solution and blood from non-pregnant women. No effect was produced in the controls. Placental extracts and blood from pregnant guinea pigs had little or no effect.

Further studies will be made along this line in the hope of obtaining a product which may be safely used in terminating human pregnancy when necessary. G. R. H.

OVARIAN TUMORS IN PREGNANCY.

Danforth, W. C.: "Ovarian Tumors in Pregnancy." Sur., Gyn. and Obst., March, 1915, Vol. XX, p. 319.

The author reports a case of pregnancy complicated by a solid ovarian tumor and discusses the general relationship of ovarian tumors and pregnancy.

The two conditions are not frequently found together. McKerron estimated the usual frequency as about one in 1,500 pregnancies. Dermoids form about twenty-five per cent of all the solid tumors found.

In the great majority of cases the progress of the pregnancy is not materially influenced. Torsion of the pedicle is the complication most frequently occurring. It is more apt to occur in tumors lying up in the abdominal cavity. Torsion of the pregnant uterus is sometimes caused by the tumor. Very large tumors seem to predispose to abortion.

The diagnosis in general is easy as a rule, although often there are no symptoms and

the tumor is found at routine examination. Diagnosis between solid and cystic tumors is often hard. Difficulty also occurs at times in diagnosis between ovarian tumors and fibroids, a retro-flexed pregnant fundus, or tubal pregnancy.

Prognosis as regards the mother depends largely on the location of the tumor, the promptness with which it is recognized, and the skill of the operator. A small tumor is much more apt to occupy the pelvis than a very large one and therefore the size of the tumor is less important than its position. Cases with torsion of the pedicle can usually be saved by prompt operation. Rupture of the cyst is the most dangerous complication, especially if suppuration of the contents has occurred.

Prognosis as regards the child is more serious than as prognosis as regards the mother. However, the chances of the child are greatly improved by early removal of the mass.

The only treatment recognized by the author is removal of the tumor as soon as the diagnosis is made. The abdominal route is the one preferred by most operators. The operation should consume the minimum of time and there should be as little handling of the uterus and appendages as possible.

When the case is not seen until labor is begun, the mass may be sometimes removed by laparotomy if the case has been handled in an aseptic manner and all the advantages of a modern hospital and a skilled operator are at hand. If not then the tumor should be, if possible, pushed up out of the pelvis and the child extracted. Delivery by forcefully extracting the child alongside the mass should never be attempted.

G. R. H.

RINGWORM INFECTION OF THE GENITO-ANAL REGION.

Trichophytosis Cruris Inguinalis. Windell, J. T., Urological and Cutaneous Review, 1915, Vol. IX, p. 10.

Windell gives the history of a recurring ringworm infection of the genito-anal region of a patient, which was traced to a seeming focus of infection in the anal or rectal mucosa, the disease had recurred so often that the case was somewhat of a puzzle; the source of the infection was not

discovered until the patient had been referred to a surgeon for rectal treatment. The writer in his article reviews the subject of Trichophytosis, especially the etiology and recent treatment for the disease.

J. L. K-S.

BORIC ACID IN TREATMENT OF SKIN DISEASES.

Montgomery, Douglas W.: The Employment of Boric Acid in Diseases of the Skin. Journal of the A. M. A., 1915, Vol. LXIV, p. 883.

The writer thinks that the treatises on skin diseases do not give sufficient notice to the use of boric acid in the treatment of skin diseases; owing to the soothing, mild and non-irritating antiseptic properties it should be thought of more frequently, whether used as an ointment alone or combined with other remedies, or as a lotion, poultice, or wash, boric acid is efficacious. The article gives a number of skin conditions in which boric acid may be used with benefit, dealing in some detail with the various ways of using boric acid poultices, lotions and ointments.

J. L. K-S.

SPOROTRICHOSIS.

Hayes, R. H., and Cherry, S. L.: West Virginia Medical Journal, 1915, Vol. IX, p. 303.

Hayes and Cherry report the first recorded case of Sporotrichosis in West Virginia. They believe that other cases have been seen but mistaken by the profession for syphilis or tuberculosis. The case reported was that of a middle aged farmer, the first lesion appeared at the base of the little finger, in appearance a warty-like growth or gunma, which showed ulcerations and a thin serous discharge; six weeks later a series of nodular lesions appeared at intervals along the outer surface of the arm, these nodules were of a dark color, tender, but there was no evidence of softening; the lymphatics in the arm and axilla were enlarged. One of the nonulcerating nodules was opened under aseptic conditions and cultured on blood serum at room temperature; the third day a pure culture of Sporotrichosis Schencki was obtained in four of the six tubes incubated. No organisms were found in smears made direct from the lesion. The patient was given potassium iodide in increasing doses with prompt results.

J. L. K-S.

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

Jacksonville, Florida, May, 1915

Number 11

ORIGINAL ARTICLES

MISDIAGNOSED CASES OF COMPRESSION OF THE SPINAL CORD.*

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Washington, D. C.

Compression of the spinal cord presents a syndrome so clear that there should be no mistaking it; yet the cases here reported show for how long a period this condition may be overlooked, to the great suffering of the patient. One of the patients was treated for rheumatism for several months; and the disease was only detected when aneurism was suspected and a consultant called, who quickly found the need of a neurologist, by whom the diagnosis was at once made. Another patient went for a week without a correct diagnosis, although suffering acute pain, an alienist having diagnosed infantile paralysis. In another case a different alienist entirely overlooked the spinal condition, mistaking a toxi-infectious psychosis which had succeeded a small dose of narcotics for dementia precox and sending the patient to an asylum, from which of course she was discharged in a few days. None of these errors would have been made had a proper neurological investigation been conducted clinically, but an examination of the reflexes or the sensibility seems to be the last thing to enter the head, even in cases where severe pain is accompanied with no objective signs in connective tissues or muscles. The all-too-ready diagnosis of "rheumatism" is made without proper investigation. Innumerable cases of

tabes have been thus allowed to go without proper treatment. See Case III and Case IV.

CASE 1. A woman of twenty-nine seen with Dr. Charles White, who had consulted an alienist a week before, who diagnosed poliomyelitis. She had a history of gradually increasing weakness of the legs, with pains for some months and a sudden paraplegia two weeks before.

Examination showed marked atrophy of the lower extremities, and complete helplessness with the exception of slight capacity to extend the right hip and flex the right leg. There had been muscular twitchings and cramps in the night. Decerebrate movements were easily provoked upon stimulating the skin. Sensibility to pin prick was absent below the knees and was much dulled in the thighs and lower abdomen as far as the eleventh thoracic segment; the deep reflexes were absent and there was extension of the great toe on stroking the sole.

The diagnosis was spinal and radicular compression by a growth, probably granulomatus. A lumbar puncture was recommended to decide its nature. On examination the fluid slightly yellow was reported to contain thirty-eight lymphocytes per c. mm., and a considerable increase of protein.

The diagnosis made was syphilitic radiculitis; the prognosis given was good; salvarsan was given four times intravenously. One month later the muscular weakness was greatly diminished, the patient could walk quite well, the sensibility had returned, save a slight dulling in the feet; the plantar reflex was no longer in extension; only the patellar reflex was still absent. Two weeks later the cerebro-spinal fluid presented only eleven lymphocytes in the c. mm.

*Read by invitation before the Duval County Medical Society at Jacksonville, March 2, 1915.

CASE II. A widow of thirty-three had sudden pain in the back and knees three months before I saw her for Dr. W. Earl Clarke. One month before the pain became worse, and retention occurred, there was also constipation, headache and pain in the shoulder, and she became delirious for three days after receiving five grains of trional and one-sixth of a grain of heroin. She was seen by an alienist who diagnosing dementia precox; sent her to an asylum, from which she was quickly returned; the pains however did not cease.

Examination showed great inequality of the reflexes, that of the right patella being greatly exaggerated; while the Achilles reflex on that side was absent and there was plantar flexion.

The left side on the contrary showed a normal patellar reflex, while the Achilles jerk was increased to the degree of clonus. Although the plantar response when stroking the sole was extensor, when the fibular border of the heel was stroked, the great toe flexed. The gluteal and the left upper abdominal reflexes were very feeble. Sensibility to pin was much diminished in the lower two-thirds of the legs, especially the left and over the third, fourth and fifth sacral segments in the gluteal region. Deep pressure was very unpleasant over the Achilles, especially the left; there was hyperæsthesia over the third, fourth and fifth lumbar vertabræ.

The motility was much impaired especially in the left leg, where all the movements were absent except the extension of the foot and hip; on the right side she can also feebly reflex and extend the thigh. The iliopsoas was very weak on both sides, but abdominal strength was retained and the gluteis were fairly strong. Fæces and urine were retained without consciousness of their presence. There had been cough and expectoration for some years and the patient, a small woman, had lost twenty pounds since last October.

The diagnosis made was a granulomatous condition of unequal distribution over the sacra-lumbar roots and compressing the spinal cord at least as high up as the first lumbar segment. The nature of the growth was believed to be tubercular and a lumbar puncture was recommended. The fluid was reported to contain ninety-eight white cells to the cubic millimetre, of which two-thirds only were lymphocytes and an enormous increase of protein.

This opinion was afterwards confirmed by the bony deformation which occurred while the patient was supine on a frame which was designed by Dr. Erving to keep the parts at rest. After some weeks of great weakness, mental depression, nervousness, insomnia, lack of appetite and an aggravation of the spinal irritation, shown by painful cramps and startings of the lower extremities, the patient turned the corner, thanks to careful nursing at Miss Thompson's sanitarium, well chosen dietary regulated by Dr. Earl Clark, and persistent psychotherapy by myself. When the hot weather began she went with her mistress to the North, and is still there, greatly improved; having gained twenty pounds in weight, and the active irritation having completely subsided; the sensory defects having greatly improved, and considerable motility having been recovered, so that the patient could move about on crutches.

This case should be contrasted with the two following where lymphocytosis is present also, but where the radiculitis usually is less focal, less massive and longer continuance before functional incapacity occurs.

Two Cases of Locomotor Ataxia Mistaken for Rheumatism.

CASE III. A lawyer from Pennsylvania had had pains treated as rheumatic for six years; latterly these had increased and some numbness and unsteadiness in gait and micturitional difficulty had supervened. His left eye and ear too were losing function. When he was referred to me, I found the left

patellar and Achilles reflexes absent; the left pupil dilated, irregular and paretic to light, the pain sense dull and delayed in the lower limbs and thorax; tremor of the tongue; slight slow nystagmus; slowed diadicokinesis, a stamping and occasionally uncertain gait, with left rhomberg; the Wasserman reaction was negative, but in the cerebrospinal fluid we found thirty-eight cells per c. mm. and an increase of protein. He was given four injections of mercury and two of salvarsan. At first the pains were increased, but they quickly ceased. Forty days after, there were only thirteen cells per c. mm. in the spinal fluid; five months later, the diadicokinesis was normal, the gait was improved, there was less tongue tremor and no nystagmus, the sensibility, except in the left tibia, had returned, although the left pupil had remained paretic; but the pains having returned, were quickly dissipated by salvarsan; and he was urged not to neglect the injections as he had done. The following year he again returned for examination and only nine cells per c. mm. were found in the fluid. Although he had practically no further trouble he was again given salvarsan twice. It is now about three years since he was first seen and he remains quite well without any ataxia.

CASE IV. Two years ago I saw a woman from West Virginia who had been treated six years for rheumatism at Clifton Springs and other places. She showed great loss of weight and strength, marked ataxia, almost complete loss of pain, vibration and attitude sense of the lower limbs, as well as loss of the tendon and pupil reflexes. She was recommended salvarsan and mercury, against the opposition of several physicians. I saw this patient only a few weeks ago, and although she has had only four periods of treatment of two salvarsans and from four to six weeks of mercurial injection in each, she is perfectly well and at normal weight save for the lost reflexes and a slight sensory loss in the tibial border of the feet, and can work with enjoyment again.

Tumor Involving the Cord Located by Neurological Examination.

G. H. R., aged forty-eight years, German, married, a printer by occupation. Was admitted to Garfield Hospital February 21, 1910.

Previous history: Had always been healthy, one attack of gonorrhea when young, no lues.

History of present illness: Four years ago began to have dull aching pain in the left shoulder, which, until July, 1909 (seven months ago), was the only symptom.

About this time the pain spread to the other shoulder and to the spine.

In the fall of 1909 the pains became sharp and spasmodic; occurring when he sat in one position for any length of time or turned his body suddenly, also when at stool, or when he coughed or sneezed, and even sometimes upon swallowing. The spasms of pain gradually increased in frequency so that he was obliged to hold his head in a certain position, *i. e.*, when lying down the head was inclined forward, with the chin approaching the chest. Turning the head too far to either side produced a spasm of pain which continued until the head was returned to the above described position. When standing he had more freedom of motion, but was apt to have a sharp, steady pain when the head was turned to either side rather than the spasmodic variety. It was an effort to hold the head erect, the shoulders also fell forward, especially to the left. Emotion or change of temperature might bring on pain.

In October, 1909, he had entered an institution for treatment after consulting numerous physicians. Here he received electricity and various forms of baths and packs. While taking this treatment he became quite ill with fever and delirium. Strange to say, the pains subsided and did not reappear for three weeks thereafter.

In December, 1909, he was referred to an orthopedic surgeon, who put him in various forms of casts, which gave considerable relief, probably by limiting motion. About

February 14, 1914, the legs and feet began to swell and he began to become quite weak in the lower extremities. Up to this time the symptoms had been quite sensory. From now on the motor disability advanced rapidly. On February 21st he had to be catheterized for the first time, though for several weeks there had been at times trouble in starting the urinary flow. About February 10th he began to notice that the rectal control was not good, *i. e.*, he was obliged to respond immediately to the desire to defecate to avoid an accident. There had been no loss of weight.

Result of Examination of Nervous System, February 22, 1910.

Reflexes: Radical and olecranon exaggerated; abdominal absent; cremasteric weak on right side, absent on left side; knee jerks exaggerated on both sides, as were the ankle jerks; toe extension, more marked on left.

Sensation: No loss of sensation to wool anywhere. On the left anteriorly pin pricks were felt over C8 (the eighth cervical segment of the cord) though there was hypoaesthesia over this area. Loss of sensation to pin pricks from D1 downward (the first dorsal segment of the cord). Posteriorly from D4 downward. On the right side anteriorly lost from D4 and posteriorly from D5 downward. Relative hypoaesthesia to coldness over same segments. The eighth cervical area was not affected on the right side. No loss of sensation to warmth on the left side. Delayed and diminished sensation to ice over D1 and D2.

Vibration test: Definite diminution in sense of vibration D1 as against C7. Could feel sense of vibration over the spinous processes of the seventh cervical which could not be felt in the dorsal region. Diminution of the spacing sense on the third and fifth fingers of the left hand.

Motor symptoms: Lower extremities quite weak, walked with difficulty. Left arm somewhat weaker than the right. Abduction

of the fingers much weaker than abduction on the left, this included the thumb and little finger. Movements of all the small muscles of the left hand much weaker than normal except the abductor of the thumb and the abductor of the fifth finger. Flexion of the thumb was weak.

The more important points were as follows: the long duration of pain, the fact that it might be produced by sneezing or coughing, the attitude of spinal flexion, rigidity, with the suddenness of onset of motor symptoms seemed to indicate root pressure (tumour of the meninges), pyramidal pressure was shown by loss of cutaneous and exaggeration of deep reflexes, Babinski's sign being more marked on the left, together with more marked signs of left-sided involvement, suggested that the tumor was on the left side of the cord. Escape of the sense touch shows how hard it is to interrupt conductively.

Localizing Symptoms.

Sensation: The higher level of the loss of sensation to pin pricks on the left in the absence of the Brown-Sequard syndrome, indicated that the lesion might be higher on the left side. That the lesion was as high as D1 was indicated by complete loss of pain sense over that segment, and that it projected to C8 was indicated by diminution of pain sense over that segment. Diminution of sense of vibration indicated the same level, as did the hypoaesthesia along the ulnar border of the left arm, and disturbance of spacing sense of left hand.

Motility: The same segment was indicated by the weakness of the small hand muscles and relative strength of the abductors of the thumb. The Wasserman reaction was negative. The leucocyte count ranged from 9,000 to 13,800.

Operation: Performed by Dr. L. H. Reichelderfer, February 23, 1910. The cord was exposed by the removal of the laminæ of seventh C and first D. The tumor, at first invisible, was found on ex-

ploration,* lying upon the left lateral aspect of the cord, and after opening the dura, to which it was attached. It was also adherent to the pia, but could be separated from the latter without injuring it. The pain was not relieved, however, nor were the nervous symptoms, except that the reflexes were no longer exaggerated. Death occurred seven days later. The temperature reached 107.2 Fahrenheit shortly before death. Microscopic examination showed the tumor to be fibrosarcoma.

Two days before death acute bulbar symptoms intervened with paralysis of muscles of tongue, pharynx and larynx, and hyperthermia temperature over 107, sighing and difficult respiration. At necropsy the medulla and cord were found exceedingly dry with minute roughenings of surface. It was believed that excessive escape of cerebro-spinal fluid was the cause of death, as cultures were negative and no meningitis was present. Some months later a paper was published by Dr. Pearce Bailey relating similar accidents and attributing these to a dry bulb.

Other Conditions Which Are Apt to Be Mistaken for Compression Without Proper Neurological Study.

The cord changes in pernicious anemia are due to the permeability or friability of the blood vessels, in consequence of which an exudate of plasma escapes into the cord and destroys portions of it, generally in an irregular fashion; so that there is not a system disease properly speaking. Of course, if there is a focus low down in the posterior column, there will be an ascending degeneration just as one finds in tabes dorsalis, consequent upon the involvement of the posterior roots in a syphilitic lepto-meningitis. Again, if the exudates occur in the lateral columns, we may find spastic symptoms be-

cause of the implication of the crossed pyramidal tract. As a rule, indeed, the sclerosis which ensues upon the exudates is scattered in such a way as to create the clinical picture known as mixed sclerosis, which easily distinguishes it clinically from tabes dorsalis. In syphilitic endarteritis, however, we may find a similarly diffused process; so that the differential diagnosis must be made from the condition of the blood.

In a case seen with Dr. D'Arcy McGee, in 1912, the clinical picture was so characteristic and severe that the diagnosis was made from that alone to the profound surprise of the attendant physician who had not suspected anything of the kind. A very bad prognosis was given, the blood examination confirmed the diagnosis and the patient died in six weeks.

In another case seen with Major Johnstone of the Walter Reed Hospital, and also unsuspected until my examination of the nervous system, the blood picture was less typical and considerably improved by the treatment. A better prognosis was permitted by the more gradual onset of the changes in the cord.

The resemblance of the pernicious anemia cord picture to that of compression is only superficial and because of the preponderance of the lower limbs in the clinical picture. A proper neurological examination, however, will, in most cases, reveal perturbations of the functions of the upper extremities also, and the absence of pain in conjunction with the diffuseness of the lesions enables us to exclude spinal compression.

A condition often widely diffused and very puzzling in diagnosis which gives many of the signs found in cases of pernicious anemia, such as spasticity, paraplegia, numbness, tingling, burning, cold sensations, formication, disorders of attitude sense, and perhaps muscular weakness is serous meningitis; and I publish† a carefully

*Had I not been so insistent upon the correctness of the diagnosis, the surgeon would have closed the wound, so normal seemed the parts and so reluctant was he to explore.

†N. Y. Med. Journal, Vol. CL, 1915, p. 824.

observed case in which compression was diagnosed and the true condition only suspected and verified at operation by Dr. W. P. Carr, who had referred me the case.

LARVA MIGRANS *

HENRY C. DOZIER, M. D.,
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Mr. President, and fellow members of the Association of Seaboard Air Line Surgeons—I desire to present for your consideration, some cases of Larva Migrans which have been very interesting and instructive to me, not only on account of their comparative rarity, or from any originality in the forms of treatment that I have adopted, but I believe that I have been able to learn something more about the disease itself, more at least than I have found in the books at my disposal. I assure you that any corrections or additions that any of you may care to make, will be gratefully accepted by me.

First let me review a few of the case histories:

CASE 1. In July, 1913, a little girl (L. T.), four years of age, having just returned from a visit to her grandmother, who resides on Lake Harris in Florida, consulted me for an eruption which the mother thought was "ground itch" between her toes, but which the mother said had spread in zig-zag lines on the dorsum of her foot, in spite of her home remedies with which she had always cured ground itch before. Having in my library a copy of "Jacobi's Dermochromes," and having only recently looked through all the plates, and noted his rather striking illustration of creeping eruption, I was able to recognize this case at once.

This was my introduction to a disease which was destined to become quite com-

mon in my practice. No longer than a week had passed, when another one of my patients appeared for treatment for another rather refractory case of "ground itch," which the mother was unable to cure.

CASE 2. Chester R., a boy, age seven years, who had shortly before returned from a trip to Lake Weir, Florida, and exhibited the characteristic linear, creeping eruption, on his toes and instep, which itched intensely. I noted, by reference to Jacobi again, that the treatment "consisted in digging out the animal or in incising the portion of skin in which it is located." Looking the matter up in "Pusey's," "Principles and Practice of Dermatology," I found the encouraging information that the "treatment consists in destroying the larva which is difficult, because all except the Russian observers have failed to locate it." I made an attempt to locate the larva in the first of these cases, and failed; so I determined to make an application and tell the patient to return the next day—thereby gaining time to look the matter up a little more fully. This dressing was applied as follows: First, I painted the entire area covering the eruption, and well beyond the margins with iodine, then applied a wet dressing of a 1-1000 solution of bichloride of mercury and instructed the mother not to remove the dressing, but to keep it wet with the solution which I gave her, and to return the next day.

That very same afternoon a copy of the Journal A. M. A., came, containing Rudell's article, describing the method he pursued in recovering the larva in his two cases. So accordingly I procured a good magnifying glass to go after the "bugs" in my case, when it should return the next day. Next day, however, upon removing the dressing, I found the entire area was blistered, and the epidermis came away with the dressing. With my magnifying glass I was unable to find anything resembling the larva; but noted the outline of the bur-

*Read before the Association of the Seaboard Air Line Surgeons, October, 1914, and awarded first prize. Subsequently read before the Marion County Medical Society.

row, which looked like a very shallow tortuous ditch. A simple zinc oxide ointment was applied, and the case was well in a week.

In case two, the seven-year-old boy, I endeavored to recover the larva according to Rudell's method, but every time I touched the child with my small cataract knife, he would jerk away and in fact was apparently so frightened, that it was impossible to even inject a little cocaine solution, much less open or scarify the burrow; so I applied the iodine and wet bichloride of mercury dressing as in case one, and secured equally prompt and effective results. Since the above cases have come into my practice I have seen some eight or ten cases, and in small children I always find it difficult to recover the larva, on account of the fright or pain occasioned by scraping or cutting, but have always found the above method certain and easy.

CASE 3. (T. H.), age about five years, same as case one, only had just returned from the sea-shore, same treatment, same results.

CASES 4, (R. McK.), 5, (R. A.), 6, (H. D.), were men in whom it was easy to secure a cure by scraping off epidermis over entire burrow, and painting with iodine. The necessity for opening the entire burrow will be shown in Case 9. In Case 6 the larva was recovered, according to the method of Rudsell.

CASES 7 and 8 were not treated or seen by me, but were the patients of Dr. Lane of Ocala, and are mentioned by me because one was infected in Georgia and one in Delaware, as I wish to show the wide distribution of this so-called rare disease in America.

CASE 9. For the privilege of incorporating this case in my report, I am indebted to Dr. W. K. Lane, who was the patient himself, and to Dr. A. L. Izlar, who was one of his attending physicians, both of them residents of Ocala, Florida. This is the most interesting case, that has, to my knowl-

edge, ever been reported; not from the standpoint of treatment, but because of the interesting facts which we believe we have been able to learn relative to the symptomology and pathogenesis of this peculiar disease. The history of this case is as follows:

On Monday in July, 1913, Dr. Lane and family were taking an automobile ride in the evening, when they had what is known as a "break-down." It was necessary for the doctor to get under the car, and in using gasoline to wash some part, it ran down his sleeve and soaked his coat and shirt. When he arrived home his back was red and covered with many small blisters. The blisters healed rapidly, and the Thursday following he took a trip to Lake Weir, Florida, for the purpose of taking a bath in the lake. Before going into the water, he took his bathing suit by each end and drew it quite a number of times across his back—because he said it made him feel good—but in doing so he left many small raw points where the blisters had healed. On coming out of the bath his back began to itch. Next day, Friday, his general condition was such that he had to quit work, and on Saturday he had to go to bed.

This general condition, which began on Friday—one day following his bath in the lake, and which gradually became worse, consisted of fever, which never reached over 101 degrees, action of kidneys, bowels and skin gradually became less until they were almost arrested, skin was dry, hot and yellow, and he was very nervous and sleepless. Pulse ranged from 120 to 160 beats per minute. Locally on his back and arms there were over 300 points of infection with the larva migrans. Eruption typical—"long, straight and zig-zag and curved lines, a sixth to an eighth of an inch in diameter, often intersecting, but never bifurcating." Itching and pain intense; described by the patient as like that of a wasp sting. By opening and touching with

iodine the advancing end of the line, and slightly in advance of this point, the line invariably ceased to advance, and the old burrow to gradually grow less distinct. But about the tenth day, at some point along the burrow, behind the advancing end, a pimple-like formation would appear, and if let alone another burrow would start from this point. By scarifying this pimple-like formation, and touching it with iodine, the pimple would dry up and no new burrow would result. We naturally concluded that the larva in advancing deposited eggs along the burrow, and made it necessary to scarify or open the entire burrow in order to be sure of the complete eradication of the larva.

I, therefore, believe that we are justified in drawing the following conclusions from the foregoing cases:

First. At least one source of infection is from water, and therefore from other insects besides the bot-fly.

According to Pusey and Stelwagon, Sekaloff and others have succeeded in recovering this larva, and consider it the larva of a "bot-fly order of diptera, genus *gastrophilus*." Pusey states that "the means of entrance of the larva into the skin is undetermined, but is probably by the deposits of the ova in the skin, by the insect." In looking up the bot-fly, in the *Americana* and other encyclopædiæ, I find that the "oblong, light yellow eggs are glued one by one to the hairs of the fore part of the body—where they are sucked off" by the animal bitten. If the larva of creeping eruption is that of the bot-fly, it would certainly not gain entrance under the skin by being swallowed in the alimentary canal, but it seems more probable that there would have to be a point of entrance, and the fly in lighting on the skin might leave one of her eggs on such a point, from contact with the forepart of her body, to which her eggs are attached. But if the bot-fly is the source of the larva of this eruption, it does

not seem that it can be the only source. In all of Stelwagon's cases, in all of my cases and also in many instances reported by others "the malady began at or after a visit to the sea or sea-shore or lake. In none of my cases were any of my patients able to recall any fly bites or even having been annoyed by flies, but all had been bathing or wading in either lake or ocean, just prior to the beginning of the eruption. So that it has occurred to me, that probably the larva originates from the gad-fly, common horse-fly or deer-fly, who "attach their eggs to water or wet earth, and are carnivorous—feeding on other insects." Might not they also feed, or at least attach themselves to a bather? And, if a point of entrance, such as that noted in the case of Dr. Lane, or such as is so common on the hands and feet of most children be present, might it not give rise to the so-called larva migrans? The case of Dr. Lane (who, as has already been stated, suffered from over three hundred separate points of infection, and who was certainly not bitten, nor was he in contact with 300 bot-flies) shows conclusively, to my mind, the probability of the water being a source of infection by the larvæ of certain insects, and also the probability of the necessity of some break in the skin being present for the larva to gain entrance beneath it.

Second. The advancing larva deposits its eggs along the burrow in some cases. This is evident by the fact of a pimple-like formation appearing along the old burrow about ten days after the original infection, and even after the original larvæ had been recovered or killed. So far as I know this fact has not been observed, or at least has not been recorded in any works at my disposal. It may account for Pusey's statement "that the duration and extent of the wanderings of this larva are indefinite. It usually goes on for several months; in a case of Croker's it continued for two and one-half years." It certainly seems possible

that the long continuation of the eruption as recorded by Pusey, might have been due to the continuous development of eggs, deposited by the advancing larva in the course of its burrow. At least it suggests the advisability of scarifying or opening the entire burrow, and treating with iodine, to be sure of eradicating the larva in many cases. It is a fact that "some larvæ among insects may breed, by a phase of reproduction called parthenogenesis, a method of reproduction in which eggs develop without impregnation; instances are abundant in insects, rotifers and lower crustaceans."

Third. A person may be infected by any number of larvæ. Stelwagon states that "exceptionally, there is more than one parasite present (rarely more than two)." The case of Dr. Lane, who had more than 300 separate points of infection, shows the possibility of any number of infections, depending, I believe, on the presence on the body of the patient of many points of entrance; Dr. Lane causing, by the irritation of his back with his bath suit, many minute denuded area, which were the points of entrance for the larva, in his case.

Fourth. When a patient is infected by a large number of larvæ, there may be a marked and extreme toxemia. I find no mention of this in any works available to me. Dr. Lane's pulse, temperature, blood and secretions did not become normal until all larvæ were destroyed. His weight decreased from 201 pounds to 148 pounds in two weeks.

Fifth. Creeping eruption is more common than has been taught. All authorities begin their articles by stating that larva migrans is a rare disease in the United States, yet our cases were from Delaware, Georgia and Florida; Dr. Rudell's cases were in North Dakota; Dr. Stalwagon's four cases were, I presume, in or around Philadelphia; and Dr. Morehead reported five cases in the Texas Medical News in 1906.

Sixth. In children with small areas involved, who from fear, temper or inability to stand pain of scarifying or opening burrow, the treatment with iodine and wet bichloride of mercury dressings as directed, is sure, safe and prompt. Treatment by freezing with ethyl-chloride, and by the use of chrysarobin ointment, or painting the surface, covering eruptions and well beyond edges with chrysarobin in collodion have been used successfully.

TRACHOMA.

F. P. HOOVER, M. D.,
Jacksonville, Fla.

Of all the diseases of the eye, none are more deserving of greater care and consideration than trachoma, and neither should the diagnosis of trachoma be made without a positive assurance of the fact. I have on many occasions been consulted regarding eyes which have been pronounced trachomatous, especially children sent home from school to have treatment for their "sore eyes," and frequently an error had been made in the diagnosis. It were better, however, to have such errors than fail to recognize a severe inflammatory condition of the eyes and their consequent result. I have had cases of blindness from neglected trachoma, in some the degree of deformity was horrible, almost complete obliteration of the sac and various other changes resulting from contraction of the palpebral conjunctiva. Granular lids, the other name for trachoma, owing to the fact that the small elevations on the inner surface of the lids resemble granulations seen in the healing of wounds; there is, however, a considerable difference between them but they both have the same results, viz., cicatrization. The disease is both contagious and infectious, thus epidemics in schools, etc., with which many cities have had to contend in the years gone by.

The cause is not certain but due to a coccus called trachoma coccus. In the early stage it is hard to differentiate it from an acute catarrhal conjunctivitis, there is first an irritation, then burning and swelling of the lids and grittiness felt; a few days later a purulent secretion will make its appearance more or less abundant, the lids when everted will be found covered with granulations. It is always well to bear in mind that catarrhal conjunctivitis has all the symptoms as above, but the secretion is more decided than in trachoma. Later, in trachoma the lids become less swollen and pain, etc., disappear. The granulations become flatter and no longer red as formerly; it is at this period that radical treatment should be employed in order to head off or abort the disease, otherwise cicatrization will result, the granulations no longer visible and the cicatrices, or scarred tissue, may be very extensive, producing contraction of the palpebral conjunctiva, or a hard unsecreting mucus membrane. Continuous friction of the lids, roughened by scar tissue, on the cornea, causing it to become vascular, cloudy and uneven, and blindness is not an uncommon result. The lids are with difficulty kept open, after being stuck together with the discharge, owing to the more or less intolerance to light. The best treatment is to remove the cause and treat the eyes on general principles, by that I mean operation by expression; this is the only safe and satisfactory mode of procedure. In the acute cases I use the forceps; they will be of no avail in the cicatricial or chronic form of trachoma. In the latter cases the bluestone, or copper stick, is the best treatment; it should be applied every other day and passed under the upper lid into the cul de sac; if this is neglected the best result will not be secured. The lower as well as the upper lid should have application made to same. Be sure and wipe out any surplus sulphate copper before the lids are returned to their natural position. When applying silver nitrate in solution I have failed to get a good result, but

I have found applications of nitrate silver stick beneficial to touch the granulations; but never the mucus membrane, in acute trachoma.

In closing let me say, it is well to bear in mind that the prolonged use of atropine will cause the formation of granulations which are similar to those of trachoma, consequently when attending a case of trachoma one should be most careful in the use of this drug, as I think it augments the disease instead of doing good; particularly as iritis is seldom a result of trachoma and atropine is used mainly in the eye for this complication. When applying a sulphate of copper stick I never use cocaine for the reason pain is prolonged instead of modified, after the treatment. Since medical inspection of public schools has existed trachoma has been less prevalent. I always caution parents to keep a close watch on their little ones' eyes and whenever there seems anything unnatural about them it is wise to have them at once looked after and thus possibly save discomfort and suffering. As a rule a small child will put up with considerable annoyance with an eye, and do much rubbing with their fingers and knuckles before complaining to their parents, and then they have something to say, which is: "My eye pains me," and the child *does not exaggerate*.

Mutual Life Building.

TREATMENT OF TUBERCULOSIS.*

D. C. THOMPSON, M. D.,

Pensacola, Fla.

The subject of "Treatment of Tuberculosis" is a difficult one to discuss because every physician has theories of his own. It is an important topic because, under present conditions here, the prognosis is always considered very bad. It is an interesting subject, for the treatment of tuberculosis will try the patience of the physician to the

*Read before the Escambia County Medical Society, at Pensacola, January 26, 1915.

utmost, also that of the patient and all concerned.

It seems to be the consensus of opinion that "rest" is the main essential in the treatment of tuberculosis. Some fifty years ago Hilton taught that rest would cure certain abscesses and certain diseases of the bones and joints which have since been proved to be tubercular in character. It was a long time, however, before the principles of rest were applied to the lungs.

Paterson of the Brompton Hospital Sanatorium in England devised a system of graduated rest and graduated work so that the patients when discharged would be fit to resume their labors. By studying the opsonic index of the patient so treated, he worked out the theory of auto-intoxication. This theory is that a patient while working liberates in his own body a toxin the amount of which is directly proportionate to the labor expended. This toxin, if it raises the opsonic index increases the resisting power of the patient, reduces the temperature; and when the highest grade of work is reached, there is an immunizing response on the part of the patient with an opsonic index resembling that of normal individuals. It is really a carefully graded auto-inoculation of tuberculin in gradually increasing doses. If the work is too severe, the amount of toxin or tuberculin liberated is too great and produces a reaction with a drop in the opsonic index and a rise in temperature with harmful results. The same effect is produced by the administration of tuberculin.

One noted physician in Australia claims to have treated tuberculosis with marked success by the use of tuberculin alone and went so far as to state that he never lost a case so treated. Perhaps he got his cases early before there was a mixed infection. A mixed infection renders the case very difficult to treat by tuberculin because it is hard to know to what the reaction may be due. In this country, the tuberculins must still be considered as in the experimental stage, their value being problematical; although

in many cases certain of the tuberculins seem to give happy results.

In the *Southern Medical Journal* of February, 1914, tuberculosis in its various phases is widely discussed. Durel of New Orleans states that rest is most essential for satisfactory results. He ably discusses all the difficulties which enter into the treatment by rest. Rest of the mind is just as essential as rest of the body; and worry, financial troubles and disappointments all tend to cause a reaction which is harmful.

Climate has always been considered an important factor in the treatment of tuberculosis. Osler says, "the requirements of a suitable climate are a pure atmosphere, an equable temperature not subject to rapid variations, and a maximum of sunshine." Early cases are better off in high altitudes; cases in the advanced stages do better in low altitudes but, in any altitude, humidity is a serious drawback. I believe that each state, at least each Southern state, has the best climate for its own tubercular patients. Patients with moderate or limited means are better off at home. The worry of a tiresome journey, the home-sickness, the business difficulties more than offset the good derived from a change of climate. Wilson of Louisville states, "treatment is not a matter of climate but of discipline, routine, self-denial and training, following out a definite plan for an indefinite period."

The latest device of obtaining absolute rest to a tubercular lung, full of cavities, is producing an artificial pneumothorax by injecting into the pleural cavity, nitrogen gas until the lung has collapsed. Voorsanger of San Francisco, in his paper published in the *Journal of the A. M. A.*, of May 9, 1914, has this to say:

"The direct effect of compressing a diseased lung with nitrogen is sometimes most startling. I have seen a stubborn cough cease within twenty-four hours after complete compression; temperature drop to normal after a few days; sputum rapidly diminish, and a general all-round improve-

ment result in the patient's condition. There can be no question that artificial pneumothorax has rescued many tuberculous patients who did not respond to other methods of treatment and who would have died otherwise.

The theories of the mechanism of healing by this treatment as generally agreed on are: (1) rest to the involved organ; (2) an ischemia of the lung because of the elimination of venous circulation; (3) a diminution of toxin absorption, and (4) ultimate scarring over of diseased tissue. Perhaps more theories will evolve to explain further why we sometimes obtain such remarkable results in hopeless cases, when all other methods have proved futile. The direct effect of nitrogen on the tissues may offer a fertile field for investigation."

The crying need in this country in the treatment of tuberculosis is *sanatoriums*. Sanatoriums where treatment is supplied free to all sufferers should be maintained by each state. Poor people and those of only moderate means can not afford to care for themselves and thus become a menace to the public health and should be dealt with as a social problem. In sanatoriums patients are not only treated, but they are taught how to care for themselves so that they can continue the treatment at home under the direction of the district nurse. The source of infection is thus removed from the home and the work of the district nurse is much more effective in teaching the other members of the family the necessary preventive measures. In this climate sanatoriums on the plan of cheaply constructed houses or tents could be provided within easy access of the patient's home and everything done to put the patient at perfect rest, both of mind and body. From the London letter in the *Journal of the A. M. A.*, of February 28, 1914, let me quote:

"It may be remembered that one important feature of the national insurance act was the providing of money for the treat-

ment of tuberculosis, both at home and in sanatoriums, and also for the investigation of the disease. Under the supervision of the government, schemes of treatment have been prepared all over England so as to bring skilled advice within the reach of every one suffering from the disease. There are now between 450 and 500 approved institutions for the treatment of tuberculosis, and the building of others is rapidly proceeding. The scheme involves two units, the first being the dispensary or non-residential institution and the second the sanatorium and hospital for residential treatment. There are now 250 dispensaries, and in time one will be established in every large town and within reasonable distance of every country district. The dispensary is a center for diagnosis, treatment and after-care. The patient is either treated there or sent to a sanatorium or hospital. In suitable cases a shelter (with the necessary furniture) may be lent to him for erection in his own garden. Each dispensary is under the charge of a medical officer called the 'tuberculosis officer,' who is a specialist in tuberculosis. The tuberculosis officers are assisted by a staff of competent nurses and health visitors. The whole arrangements are under the administration of the health officer of the district. It is estimated that the total cost of the scheme will work out about nineteen cents per head of the population."

PREVENTIVE MEDICINE.*

G. H. BENTON, M. D.,

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As a matter of common competency of the modern physician in keeping with the general trend of advancement of the times, much more is expected and much more may also be demanded from the physician, whether he be concerned in general work or in some of the special branches of the

*Read before the Dade County Medical Society August 20, 1914.

profession, than have heretofore been expected or required.

The subject of preventive medicine embracing some knowledge of the many collateral sciences as well as many of the newer themes, which have not yet been admitted universally as fully competent scientific entities, are attracting the attention of the laity, as well they should, for there is much of immense value to be obtained both individually and collectively to every community, for long has the cause existed necessitating a knowledge of these measures and the adoption of such means of prophylaxis as will modify or obliterate the nefarious results of hitherto common practices.

The intense scientific activity of the self-sacrificing medical profession have established facts and inaugurated customs which are being made obligatory by our state and municipal boards of health all to the advantage physically, morally and financially of the laity, who are readily awakening to the possibilities, great as they are, and will not only desire but demand of the family physician such explanations and verification of facts and fancies as will make the facts applicable to every-day practice and dispell the fallacies of the fancies.

Thus the physican may hope to come into his own, not merely as a repairer of accidents and injuries or resuscitating a patient in the last throws of a violent illness which may render him more or less of an invalid during the remainder of life, but who by his knowledge and wise council has in advance prevented the spread of diseases and calamities concomitant therewith.

The province of the modern physician not only embraces the knowledge of the technic and application of rational and approved reparative procedures tending toward rehabilitation of the physical forces, but also a sense of the fitness of things, embracing the philosophy of cause and effect, his privilege therefore lies not only in scientifically investigating the facts, and retaining them as scientific assets, but ethics

compel him to disseminate these truths for the greatest good of the greatest number.

This leads us to the realization of extended obligation on our part, as the present horizon of preventive medicine is daily extending and expanding, adding new detail, with possibilities developing the assurance of probabilities, the final proofs only awaiting the detail of demonstration.

Again preventive medicine is not only concerned in the curtailing and eradication of infectious and contagious diseases, as great as that branch of the science is, but must deal with the present and future of the entire and complete human entity singly as an individual and collectively as classes and communities, and here is where the knowledge of the many collateral sciences and themes show their advantage. Sociology, criminalology, anthropology and eugenics throw much light on facts and suggest many advantageous modifications and procedures. Psychology is so closely allied to medical science as to be properly considered a collateral science, more specifically a collateral branch.

Our efficient national, state and municipal boards of health are concerned primarily with the problems of sanitation, quarantine, vital statistics, contagious and infectious diseases, and such problems of municipal, state and national hygiene as are competent with their authority and possibilities. The private physician, however, in addition to this hearty support of the health boards in all their activities and accomplishments has both a duty and a privilege to himself and to the families with which he daily associates.

This duty consists of the dissemination of such knowledge of mental, moral and physical hygiene as may be needed as a warning of impending danger to some, as a caution of impending possibilities to others and as a preliminary means of possible restoration, or a knowledge of how best to condone a defect or diseased condition so

as to escape the greatest adverse consequences if that were possible.

The family physician occupies a more favorable position in relation to the family circle than the clergy, and advice properly given is quite certain of results sooner or later. In education we have the most powerful means of prophylaxis and the only really rational means which can obtain in some conditions, hence the best advice from the best source must obtain the best results. I believe it the duty and privilege of every physician to discuss intelligently and completely each and every phase of mental, moral and physical hygiene to the complete understanding of the enquiring patient, thereby disabusing their minds of falacies, fancies and superstitions which may be replaced with tangible facts much to the credit of the physician and equally to the advantage of the patient and community.

Through the untiring efforts and accomplishments of the physician have the primary lessons of preventive medicine been established and are being recognized and accepted by the public, and other advances are gradually becoming more and more impressive and will continue so until the history of the present housefly will be commensurate with the almost past mosquito and like yellow fever, malaria, typhoid fever and many other diseases, will ere long have no other than historical significance, and so it may be with many other conditions of disease and defects which are now regarded somewhat as necessary evils. The knowledge of their causes and the means their prevention are being worked out within our laboratories and scientific workshops and through the medium of rational education, thoughtfulness and discretion will replace indifference and carelessness, to which end the endeavor of every physician should be enlisted.

The constantly increasing volume of defectives from whose ranks are recruited the dependent, the criminals and the insane, filling our penal institutions to overflowing,

burdening our society to an almost overwhelming degree, menacing and threatening the stability and longevity of the races, if not eventual extinction, is by right of its magnitude of impending danger demanding the foremost consideration of the civilized world.

Concomitant with the great effort which is being put forth at the present time to educate the masses against the means of transmission of contagious and infectious diseases, should go education along similar lines embracing the knowledge of transmissible defective conditions which result in similar and dissimilar heredity.

Each individual should be taught early in life that to reduce the physical standards is to invite disease and disaster and he should further be taught that the normal physical standard of any individual is the highest possible attainment of physiological perfection in each and every organ, muscle and nerve of the entire body, a commensurate physiological functioning unison.

There is no moment after birth too early to begin this necessary educational process. The first two weeks in life I consider the most important period in the whole educational career of the child, habits engendered within that period and prolonged subsequently, unwittingly vicious, obtain many times all through life in spite of any and all education to the contrary.

Every mother should know that the baby should never be handled except when necessary for food or cleanliness and then the least possible, should also understand that babies unlike dolls were not made to be played with for the pleasure of the parent or admiring friends, and should realize that the impression created during the first days of life may persist in spite of education to the contrary as long as life remains. The mother should know and fully realize that child psychology is not the diminutive adult psychology but an entirely different construction. In infancy and sometimes extending into childhood there is no desire

or attempt at analysis, hence all impressions are truth impressions and recorded as such to the extent that many times the individual is unable to erase the impression and its reaction in spite of education, desire and a complete knowledge of its fallacy. Viciously a child is told that if it go into the dark the "boggy man will get you," and all through life in spite of reason, persuasion, and education to the contrary that conscious fear remains and makes cowards of intelligent educated individuals.

Every expression to or before an infant and growing child requires strict censorship, one needs to know quite definitely the exact impression which is to be created on the infantile mind as well as its possible reaction from some knowledge of the particular infantile psychology. All the jargon, baby talk, senseless coddling indulged in by the members of the family or others to some degree is perhaps as injurious to the child as a dietary composed largely of lager beer, each possesses a particular protoplasmic poison; one affecting histologically the physiological integrity of the cell, the other affecting the histological integrity of the psychia.

And again, the continual repetition of these adverse habits of the parents or family against the child is of further uncompensated injury, for the child acquires an entirely erroneous idea of life at its start and must learn later many times by hard and bitter personal experience, which in every way are harmful rather than beneficial and from these facts also faulty deductions are made and hence further error occurs which obtain many times entirely through life.

Hereditary factors assuredly play an important role and cannot wisely be overlooked, yet in spite of common or even some adverse hereditary conditions, wonders may be accomplished by rational early educational methods systematised to suit the particular psychology of the child. Only a few years since the world was astonished

and mystified to learn of the accomplishment of two Harvard children, sons of Professor Boris Sidis and Leo Weiner, who, at the age of 11 and 13 years respectively, were able to discuss accurately and conclusively the problem of a fourth dimension. No one would be willing, however, to hazard the prediction that exactly the same educational methods applied to a number of children, even of the same parents, would produce precisely the same results in each case, but with similar methods adjusted to the needs and requirements of each particular child's psychology can be expected to obtain equally desirable results.

It would require perhaps an advanced degree of intelligence and educational preparation to produce exactly equal degrees of results as were accomplished by these two Harvard professors, yet I find it not only quite possible but being actually accomplished unwittingly by individuals of only ordinary intelligence and aptitude who, with a little instruction and encouragement, would achieve quite brilliant results.

In view of these facts is it not fully commendable that the physician who attends any patient in confinement, and especially should it be her first child, should inquire into her ideas in reference to the care and education of that child, and where she lacks discretion and judgment he will find full opportunity to suggest better methods and the reasons why his methods are better, explaining fully the process of evolution obtaining in child psychology, the advantages on one hand and the dangers on the other.

Every mother should be fully impressed that the child left alone in a comfortable position in its crib, except when it must be changed or fed, soon learns to be self-entertaining and independent. The child that is handled and coddled almost immediately demands to be entertained by others; hence we find mothers walking the floor by day and fathers walking the floor by night just to please the baby because they have taught

the baby only to be pleased by these means. This is really vicious and often persists all through life in every way detrimental to the child, during baby, youth, adolescent and adult life. This is only one of the all too common customs insisted in by parents, all equally vicious in their results and absolutely without reason or excuse.

Why should a mother rock a babe to sleep, when sleep is its most natural inheritance? Why should a mother pick a babe out of the crib when it awakens and rock it in her arms instead of placing it on the floor and allow to entertain itself rationally. Why? Habit. Custom, "that is the way my mother did." It were better in the absence of proper specific advice, verbal or printed, that the expectant mother get her pointers from the ordinary farm dam or the native Indian and expand thereon as occasion demands.

PROPAGANDA FOR REFORM.

COLCHI-SAL.—Colchi-Sal is sold by E. Fougera and Co., Inc., in capsules stated to contain the "active principle" of cannabis indica, colchicin, methyl salicylate and "appropriate aromatic adjuvants." It is recommended in "Gouty and Chronic Rheumatic Manifestations," "acute cases of Gout," "intestinal autointoxication or dyspepsia," "bilious headaches," etc. The Council on Pharmacy and Chemistry found Colchi-Sal ineligible for New and Non-official Remedies because the indefinite character of the "active principle" of cannabis indica made its composition secret, because it was advertised indirectly to the laity, because unwarranted therapeutic claims were made for it, because the name does not indicate the habit-forming cannabis indica and because the composition was held unscientific. (*Jour. A. M. A.*, March 20, 1915, p. 1016.)

DR. KLINE'S NERVE REMEDY.—This "epilepsy cure" is sold by the R. H. Kline Company, 45-47 E. Twentieth St., New

York City, this being the same address as that of the Lexington Drug and Chemical Company which sends out the Waterman "epilepsy cure" (see above). Examination in the A. M. A. Chemical Laboratory showed this bromid mixture to be practically identical with Waterman's Tonic Restorative. (*Jour. A. M. A.*, March 6, 1915, p. 848.)

GUERTIN'S NERVE SYRUP.—This is an epilepsy treatment sold by the Kalmus Chemical Co., Cincinnati, Ohio. Examination in the A. M. A. Chemical Laboratory demonstrated Guertin's Nerve Syrup to be essentially a mixture of several bromides, the bromide content being equivalent to 13.9 grains potassium bromide per fluidram. The recommended daily dose of four to eight teaspoonfuls is equivalent to 55.6 to 111.2 grains potassium bromide. While possessing all the potency for harm that resides in secret mixtures of the bromides, the purchaser of this nostrum is led to believe that it is harmless. (*Jour. A. M. A.*, March 27, 1915, p. 1094.)

LIQUID PARAFFIN (LIQUID PETROLATUM).—W. A. Bastedo reports the results of a clinical investigation made under the auspices of the Therapeutic Research Committee of the Council on Pharmacy and Chemistry to determine the relative efficiency of the different preparations on the market. Three specimens were sent out: a heavy Russian liquid petrolatum, a light Russian liquid petrolatum and an American liquid petrolatum—being distinguished only by number or letter. From extended trials in hospitals it is apparent that all acted alike. Only slight differences as to palatability were noted by some. (*Jour. A. M. A.*, March 6, 1915, p. 808.)

NEURILLA.—To show how a practically worthless mixture may be exploited by means of ill-considered testimonials, the Council on Pharmacy and Chemistry publishes a report on Neurilla, apparently the sole output of the Dad Chemical Com-

pany. Neurilla, according to the manufacturer's claims, depends for whatever virtues it has on two generally discarded drugs, skullcap and passion flower, present in unstated amounts, "aromatics" and 20.3 per cent alcohol. It is advertised as a "nerve tonic" and is said to be "A Valuable Aid in the Treatment of Fevers, Colds, LaGrippe, etc." Inquiries sent to some of the physicians whose testimonials were used to promote Neurilla brought replies indicating these testimonials to have been given thoughtlessly and on insufficient experience. In most cases the writers stated that they had abandoned the use of Neurilla long ago. (*Jour. A. M. A.*, March 27, 1915, p. 1093.)

SANMETTO.—The Council on Pharmacy and Chemistry finds that Sanmetto is a secret nostrum the exploitation of which is an invitation to haphazard, uncritical therapy and a menace to public health. It is claimed that "Sanmetto is a blending of true santal and saw palmetto with soothing demulcents in a pleasant aromatic vehicle," but neither the identity of the "demulcents" nor the quantities of the other ingredients are given. The recommendations for the use of Sanmetto are unwarranted, absurd and vicious. The advertising claims are likely to induce some physicians to belittle the importance of diseases of the sexual organs and to be content with the prescribing of Sanmetto to the detriment of the patient and the danger of the community. (*Jour. A. M. A.*, March 13, 1915, p. 926.)

STRYCHNIN AND CAFFEIN AS CARDIOVASCULAR STIMULANTS.—F. H. Newburgh has studied the effects of strychnin and caffein in acute infectious diseases. He finds that strychnin sulphate in medicinal doses does not increase the output from the heart, slow the pulse or materially raise the blood pressure. He concludes that there is no logical basis for its use as a cardiovascular stimulant. Further, he finds that caffein sodiosalicylate, in ordinary dosage, does not raise the blood pressure or slow the pulse. His experiments did not determine if caffein in-

creased the blood flow. (*Arch. Int. Med.*, March 15, 1915, p. 458.)

THEOBROMINE VERSUS CAFFEINE.—Lester Taylor finds that caffeine gives a moderate relief from the cardiac symptoms in myocardial insufficiency, but also causes the constant appearance of distressing nervous and gastric symptoms. He further finds that the clinical diuretic action of caffeine may be better performed by large doses of theobromin sodium salicylate, N. N. R., without the unpleasant side-effects. (*Arch. Int. Med.*, Dec., 1914, p. 769.)

WATERMAN'S TONIC RESTORATIVE.—Examination in the A. M. A. Chemical Laboratory showed this "epilepsy cure" to be a bromid mixture, containing bromide equivalent to 17.6 grains potassium bromid per fluidram. The recommended daily dose of five teaspoonfuls corresponds to 88 grains potassium bromid. Caring little for the health or safety of those who use the nostrum, the promoters advise an increased dosage if required "to stop the 'Fits,'" thus leaving the dosage with the user, who is assured that the nostrum is "safe." (*Jour. A. M. A.*, March 6, 1915, p. 847.)

WATERBURY'S COMPOUND.—Four years ago the Council on Pharmacy and Chemistry reported unfavorably on "Waterbury's Cod Liver Oil Compound." Having been requested to consider again the product, now known as "Waterbury's Compound," the Council found that there was no evidence that it is a substitute for cod liver oil. It held that Waterbury's Compound is advertised with misleading claims and therefore voted that no further consideration be given to it. (*Jour. A. M. A.*, March 20, 1915, p. 1016.)

WHITE SULPHUR SALTS.—This is an effervescent salt put on the market by the White Sulphur Springs, Inc. It was refused recognition by the Council on Pharmacy and Chemistry because it did not represent the water of White Sulphur Springs, Va., as claimed. (*Jour. A. M. A.*, Nov. 21, 1914, p. 870.)

Preliminary Program, Forty-Second Annual Meeting of the Florida Medical Association at Deland, Florida, May 12-14, 1914

WEDNESDAY, MAY 12th, 10 A. M.

Invocation REV. H. C. COLEBROOK, Pastor First Baptist Church

Addresses of Welcome:

On behalf of City,
MAYOR JOHN MACDIARMID.
Volusia County Medical Society,
L. B. BOUCHELLE, M. D., New Smyrna, Fla.
Business Men's League,
S. D. JORDAN, President.

Woman's Club,
MRS. W. R. STEVENS, President.
Stetson University,
PRESIDENT LINCOLN HULLEY, LL.D.
Response in behalf of the Association,
P. C. PERRY, M. D.

Reports of Officers:

Report of the Secretary.
Report of Editor of the JOURNAL.

Report of Treasurer.
Report of Librarian.

Reports of Councillors:

First District, J. HARRIS PIERPONT, M. D., Pensacola, Fla.
Second District, H. E. PALMER, M. D., Tallahassee, Fla.
Third District, C. S. BROWN, M. D., Live Oak, Fla.
Fourth District, GERRY R. HOLDEN, M. D., F. A. C. S., Jacksonville, Fla.
Fifth District, H. C. DOZIER, M. D., Ocala, Fla.
Sixth District, U. S. BIRD, M. D., Tampa, Fla.
Seventh District, DAVID FORSTER, M. D., New Smyrna, Fla.
Eighth District, J. H. HODGES, M. D., Gainesville, Fla.
Ninth District, J. S. McGEACHEY, M. D., Chipley, Fla.
Tenth District, Y. E. WRIGHT, M. D., Wauchula, Fla.
Eleventh District, W. R. WARREN, M. D., Key West, Fla.

2 P. M.

President's Address F. CLIFTON MOOR, M. D., Tallahassee, Fla.

Symposium on Pellagra.

1. "What Can Be Done for the Pellagra Situation in Florida?"
H. HANSON, M. D., Jacksonville, Fla.
2. "Pellagra,"
J. G. DUPUIS, M. D., Lemon City, Fla.
3. "The Dermatological Aspect of Pellagra,"
J. L. KIRBY-SMITH, M. D., Jacksonville, Fla.
4. "Pellagra,"
JOHN REEVE, M. D., DeLand, Fla.
5. "A Case of Complete Absence of Vagina and Uterus,"
E. W. WARREN, M. D., Palatka, Fla.
6. "Uterus Duplex,"
J. S. McEWAN, M. D., Orlando, Fla.
7. "An Unpublished Circumcision Operation, With Manikin Illustrations,"
J. HARRIS PIERPONT, M. D., Pensacola, Fla.
8. "Remarks on the Surgery of Hemorrhoids,"
RALPH DUFFY, M. D., Tampa, Fla.

8 P. M.

Oration GERRY R. HOLDEN, M. D., F. A. C. S., Jacksonville, Fla.

9 P. M.

Banquet by the Members of Volusia County Medical Society to the Members and Visitors of The Florida Medical Association.

THURSDAY, MAY 13th, 9 A. M.

9. "Tropical Abscess of the Liver, With Some Points on the Technique of Its Surgical Treatment,"
J. S. HELMS, M. D., Tampa, Fla.
10. "Suggestions Concerning the Handling of Acute Appendicitis Before the Patient Reaches the Surgeon" (two minutes).
CAREY P. ROGERS, M. D., F. A. C. S., Jacksonville, Fla.
11. "Supraclavicular Brachial Plexus Block,"
J. KNOX SIMPSON, M. D., Jacksonville, Fla.
12. "The Surgical Treatment of Prolapse of the Uterus,"
THOMAS S. FIELD, M. D., Jacksonville, Fla.
13. "Appendicitis Complicating Pregnancy,"
CHARLES L. JENNINGS, M. D., Jacksonville, Fla.

14. "Supra-Pubic Prostatectomy,"
J. V. VINSON, M. D., Tampa, Fla.
11 A. M.
Election of Officers.
2 P. M.
16. "Bone and Joint Cases from the State Crippled Children's Service,"
RAYMOND C. TURCK, M. D., F. A. C. S., Jacksonville, Fla.
17. "The Progress of Intra-Nasal Surgery,"
L. C. INGRAM, M. D., DeLand, Fla.
18. "Some Observations of Presenility of the Eyes and the Effects of Light Upon the Eyes
in this Latitude,"
FREDERICK J. WALTER, M. D., Daytona, Fla.
19. "The Importance of the Motor Nerves in Affections of the Eye,"
F. P. HOOVER, M. D., Jacksonville, Fla.
20. "Direct Laryngoscopy and Tracheo-Bronchoscopy: Report of Cases,"
H. M. TAYLOR, M. D., Jacksonville, Fla.
21. "The Tuberculosis Situation,"
J. M. MASTERS, M. D., Port Orange, Fla.
22. "Tuberculosis, a Disease of Double Origin,"
HIRAM BYRD, M. D., Trilby, Fla.
23. "Malaria Hematuria,"
J. M. IRWIN, M. D., Crystal River, Fla.
24. "Transmission of Malaria,"
GRAHAM E. HENSON, M. D., Jacksonville, Fla.
25. "Biographic Illustrations of Epileptic Seizures,"
WM. P. SPRATLING, M. D., Baltimore, Md.,
and
D. C. MAIN, D. C., Welaka, Fla.
26. "Ovarian Tumors,"
DAVID FORSTER, M. D., New Smyrna, Fla.
27. "Relaxed Vaginal Outlet; Its Diagnosis and Treatment,"
GERRY R. HOLDEN, M. D., F. A. C. S., Jacksonville, Fla.
28. "Eclampsia and Its Treatment,"
FREDERICK J. WAAS, M. D., Jacksonville, Fla.
8 P. M.
Meeting of House of Delegates.
10 P. M.
Dance at Putnam Inn.
MAY 14th, 9 A. M.
29. "Faulty Obstetrical Technique,"
W. M. ROWLETT, M. D., Tampa, Fla.
30. "Complications of Chronic Gonorrhœa,"
W. B. BUSH, M. D., Lake City, Fla.
31. "How the General Practitioner May Overcome Some of the Difficulties in the Treatment
of Gonorrhœa in the Male,"
W. MARION BEVIS, M. D., Tallahassee, Fla.
32. "Assisting Nature,"
MARY FREEMAN, M. D., Perrine, Fla.
33. "Serotherapy,"
S. C. KINGSBURY, M. D., Largo, Fla.
34. "A Plea for Better Health Organization in the Smaller Municipalities of Florida,"
M. E. HECK, M. D., St. Augustine, Fla.
35. "Acute Glossitis With Report of a Case,"
J. S. HELMS, M. D., Tampa, Fla.
36. "Some Notes on Ameba,"
C. G. ROEHR, M. D., Ft. Pierce, Fla.
37. "The Significance of a Differential Blood Count,"
M. Price DEBOE, M. D., Cocoa, Fla.
38. "Vaccine and Serum Treatment of Disease,"
D. H. SIMMONS, M. D., DeFuniak Springs, Fla.
39. "Indigestion,"
H. MARVIN SMITH, M. D., Jacksonville, Fla.

HOTELS AND RATES

Putnam Inn	.	100 rooms	\$2.50 to \$3.50	The Oaks	.	15 rooms	2.50 to 3.00
Lexington	.	20 rooms	2.50 to 3.50	Hutchinson Hall	.	12 rooms	2.00

HEADQUARTERS—PUTNAM INN

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville.
Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association,
St. Augustine, Florida, or 334 St. James Building,
Jacksonville, Fla., U. S. A.

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THOMAS TRUELSEN, M. D., Tampa. *Medicine*

GERRY R. HOLDEN, M. D., F. A. C. S., Jacksonville
Gynecology

JAMES D. LOVE, M. D., Jacksonville. *Pediatrics*

J. L. KIRBY-SMITH, M. D., Jacksonville. *Dermatology*

HENRY HANSON, M. D., Jacksonville.
Bacteriology and Pathology

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COUNCILLORS.

First District—Escambia, Santa Rosa and Walton
Counties: J. Harris Pierpont, M. D., Pensacola. 1916

Second District—Franklin, Gadsden, Jefferson, Leon,
Liberty and Waukulla Counties: Henry E. Palmer,
M. D., Tallahassee 1917

Third District—Columbia, Hamilton, Madison, Lafay-
ette, Suwanee and Taylor Counties: C. S. Brown,
M. D., Live Oak 1917

Fourth District—Duval, Clay, Nassau and St. Johns
Counties: Gerry R. Holden, M. D., Jacksonville. 1918

Fifth District—Citrus, Hernando, Lake, Marion and
Sumter Counties: H. C. Dozier, M. D., Ocala. 1915

Sixth District—Hillsborough, Pasco and Pinellas Coun-
ties: U. S. Bird, M. D., Tampa. 1915

Seventh District—Brevard, Orange, Osceola, St. Lucie
and Volusia Counties: David Forster, M. D., Hawks
Park P. O., New Smyrna. 1918

Eighth District—Alachua, Baker, Bradford, Levy and
Putnam Counties: J. H. Hodges, M. D., Gaines-
ville 1916

Ninth District—Calhoun, Holmes, Jackson and Wash-
ington Counties: J. S. McGeachy, M. D., Chipley, 1918

Tenth District—DeSoto, Lee, Manatee and Polk Coun-
ties: Y. E. Wright, M. D., Wauchula. 1916

Eleventh District—Dade, Monroe and Palm Beach
Counties: W. R. Warren, M. D., Key West. 1917

Next Meeting—DeLand—May 12-14, 1915

OUR ANNUAL MEETING.

We publish in this issue of The Journal the Preliminary Program of our Forty-second Annual Meeting, which will take place in DeLand May 12th-14th. It will be seen by a perusal of this program that nothing has been left undone, by the various committees in charge, for the edification and entertainment of the members in attendance. We believe that this is going to be the most largely attended and the most enthusiastic meeting in the history of the Association. Let all attend who possibly can.

THE NEW YORK TRIBUNE'S CAMPAIGN.

"These be parlous times for the medical faker. The *New York Tribune* recently entered the lists against the quack and the fraudulent 'patent medicine' with an educational campaign that promises to have far-reaching effects. The motto of the *Tribune* is: 'First to Last the Truth: News, Editorials, Advertisements.' Naturally, living up to such a motto bars practically all medical advertising. But the *Tribune* has gone further. A few weeks ago," says *The Journal of the American Medical Association*, "it announced that it would guarantee its readers against loss or dissatisfaction through the purchase of any wares advertised in its columns. Such a step on the part of the daily newspaper is, we believe, unique. A few high-class magazines give their readers this protection, but, so far as we know, no newspaper has ever assumed such a task as that undertaken by the New York paper. As the *Tribune* says:

"Out of our armory of defences goes the comfortable old doctrine of *caveat emptor*, that favorite refuge of the newspaper whose hands are full of not over-clean advertising revenue. *Caveat emptor* is the strict letter of the law, but we shall never retreat behind it. In practice it means that the reader takes care while the newspaper takes the money. Under our system he

does not have to take care. We will do the taking care for him.'

"Should newspapers over the country, generally, take this stand, it would sound the death knell of the fraudulent 'patent medicine' industry. Imagine, if possible, a newspaper guaranteeing its readers against loss from taking 'Pulmonol' or 'Eckman's Alterative' for consumption, from taking 'Swamp Root' or "Doane's Kidney Pills' for Bright's disease, from taking 'Wine of Cardui' or 'Lydia Pinkham's' for 'female trouble,' from taking Coutant's alleged cure for deafness, from using Plapao Pads for rupture, from taking any of the thousand and one wickedly exploited cures for cancer—imagine a newspaper that guaranteed its readers against 'loss or dissatisfaction' carrying such advertisements! It isn't conceivable that any paper that had the interest of its readers sufficiently at heart to take the stand that the *Tribune* has, could, in the nature of the case, accept advertisements from fraudulent 'patent medicine' concerns and quacks. Yet, as a normal principle, the new standard taken by the *New York Tribune*, while so far in advance of the procession, is merely one of simple, elemental honesty. It is the stand that is taken by every honest man in business. The rapid change that is now taking place in the advertising world makes one optimistic. We believe before the present decade has passed the position taken by the *Tribune* will be accepted as a matter of course by the great bulk of decent newspapers throughout the country. In the meantime, every right-minded citizen should throw the power of his influence behind those publications that are waging war against frauds and leading in the fight against those powers of evil that menace both public health and public morals. More power to the pen of the *New York Tribune*."

THE HEALTH OF OUR SUMMER RESORTS.

Many of our summer resorts have acted on the policy that a good climate, charm of

location and beauty of scenery are sufficient inducements to attract the summer visitor; but nowadays people are more wary and wisely look for more than this before selecting a vacation playground. The visitor wants a clean bill of health from the resort he has chosen, and is entitled to have one. Vacation typhoid is becoming known as a serious hazard. The prudent recreation seeker now finds out in advance whether or not this infection prevails at the place he has in mind, and furthermore learns what sanitary measures are being taken there to safeguard the health of the summer colony. The town of York, Maine, has recently taken steps that at once place it in the forefront of progress as far as health is concerned. The way the problem was met may well serve as a model for other summer resorts. Last year there were a number of cases of typhoid fever at York. No attempt was made to conceal the fact of the existence of the disease and its extent. The authorities very properly felt that the way to meet any danger was to face it in the open. An expert was invited to come to York and make a sanitary survey. The chief recommendation of the expert was that York needed a full time health officer. The town appropriated \$2,500 a year for this purpose and appointed Mr. William Eustis Brown, a graduate of the School for Health Officers of Harvard-Technology, to the newly created position. The town of York is now spending one dollar per capita per year for health, a larger sum than is appropriated by any other American city directly for a like purpose. "Public health is purchasable," the price is moderate, and York shows by its action that it intends to enjoy the best attainable protection from disease. Other summer colonies will find it to their advantage to follow the example of York, and take the necessary measures to safeguard their citizens and the strangers within their gates. People are now advised to demand the security of health that only a well-ordered sanitary department can

furnish. Our sea-shore and mountain resorts can no longer depend on nature and luck for a clean bill of health.—*Jour. Amer. Med. Assn.*, Feb. 20, 1915.

WHY PHYSICIANS ERR IN DIAGNOSIS.

"Since the announcement by Cabot that post-mortem findings reveal a high percentage of incorrect clinical diagnosis, the question as to the reason is important. In many institutions special attention has been devoted to the problem, and in the city of New York it was made the subject of a municipal report. Recently, in London, a well-known graduate school invited thirty-four specialists to speak on common mistakes encountered in their particular fields. In a review of these lectures," says *The Journal of the American Medical Association*, "Abrahams has presented an outline and analysis of the causes of error. It was, of course, surprising to find that the field of medicine could be divided into thirty-four specialties. A few decades ago such a series of lectures could include but five or six topics. Today the chest is divided into the lungs and the heart, and, says Abrahams, 'even the cardiac specialists exhibited a marked tendency to dichotomy, for a struggle between displaying his experiences as a clinical diagnostician and his skill as a mechanical cardiologist was manifest.'

"Errors in diagnosis are due to certain definite causes. The large percentage of such errors are avoidable, but only by ascertaining wherein the defect lies can improvement be possible.

"Abrahams classifies errors on the part of physicians into two groups, social and clinical.

"Social errors, under which are listed (1) bad deportment and (2) lack of tact, affect chiefly patients suffering from such functional disorders as hysteria, psychasthenia and neurasthenia. Social errors prevent the physician from gaining the necessary confidence of such patients and inhibit the

establishment of the thorough sympathetic undertaking which should exist between the functional neurotic and his physician.

"Clinical errors are due to (1) ignorance, (2) faulty judgment, (3) obsession, (4) failure to think anatomically, (5) failure to think at all, (6) reluctance to accept responsibility, (7) inherent difficulties in the case and (8) incomplete examination. Naturally these divisions may overlap in their application to any special case.

"As examples of gross ignorance, the author mentions overlooking a large amount of cerumen as a cause of deafness, or diagnosing a swelling in the abdomen, four days after labor, as 'acute metritis' when in reality it is a bladder full of urine. Ignorance itself may, indeed, be classified as the ignorance of fundamental facts, ignorance of the existence of rare conditions and the almost inexcusable ignorance of the recent progress in medical science.

"An error of judgment is the diagnosis of mental defect in a child who is merely deaf. The physician who diagnosis pregnancy when it does not exist, or vice versa, commits an error of judgment, which he always regrets far beyond what at first thought seems to be the gravity of his error.

"Much more rare is the error due to obsession; it is well-known that the syphilologist is inclined to see in every lesion the results of the widely spread *Treponema pallidum*. To think anatomically means to consider in the analysis of any local condition all the possible anatomic and physiologic relationships of that part.

"Mistakes from inherent difficulties in the case are the type which can be condoned. Circumstances alone may supply insuperable difficulties. There are human limitations. A shadow in a roentgenogram is but a shadow, and any one might mistake a gallstone for a stone in the right kidney, or a calcified gland for either.

"Sad to confess, mistakes from incomplete examination form the largest class. Nearly all avoidable blunders result from

this cause. Insufficient examinations are due usually to lack of time, sometimes to laziness. There are, of course, patients who object to complete and thorough examination. This can never be a satisfactory excuse; a case should be relinquished when it cannot be sufficiently studied. 'It is better,' warns Abrahams, 'to lose a patient than to lose a reputation.'

"Bissell and Le Count have analyzed the relations of the clinical diagnosis to the post-mortem findings in two hundred deaths in coma. In brief, their study has shown that there is a gradual increase in the number of correct diagnoses with the length of time under observation.

"There is, then, one class of mistakes which can be condoned. This class is bounded by human limitations. The others are avoidable. Mistakes due to gross ignorance and faulty judgment may be overcome and are being overcome by increased preliminary requirements and improvement in medical education and by an endeavor on the part of most physicians to keep abreast with the advance in medical knowledge. Mistakes due to lack of time and thorough study will be overcome when physicians resolve to study each case thoroughly with the use of the many available accessories to medical practice."

CANCER IN NEW HAMPSHIRE.

According to the New Hampshire State Health Department great advancement has been made in the knowledge of cancer and in what may be done greatly to reduce its mortality. In the Quarterly Bulletin for January, 1915, Dr. Irving A. Watson, secretary of the State Board of Health, points out that both the physician and the patient should realize that the early discovery and removal of this disease are of supreme importance. The only two methods of treatment worthy of serious consideration are said to be complete removal by the surgeon as soon as the growth is discovered, or, in case of superficial or so called skin cancers,

the use of X-rays or radium. But it is emphatically stated that these newer methods offer no reliable hope of cure except in the treatment of surface cancers. No paste or other preparation externally applied to deep-seated cancers like cancer of the breast, for instance, is of any use whatever; but, on the other hand, may lessen the chance of life through delay in substituting this treatment in place of early removal by the surgeon.

Reiterating the supreme importance of early discovery and immediate operation Dr. Watson says that a delay to await more pronounced manifestations of cancer greatly lessens, if it does not entirely remove, the chance of successful treatment. For these reasons the Bulletin goes on to say, "Persons of forty years of age and upward should be on guard to discover suspicious swellings, lumps, or sores, especially if painless (as cancer nearly always is in its initial stage). Any unusual condition of moles, warts, marks, etc., should be examined by a competent physician or surgeon without delay. If a cancerous growth is neglected until it becomes painful, the chances of successful treatment are greatly reduced, if not entirely lost. A lump in the breast barely discernible to the touch, not sore or painful in the least, should arouse suspicion and professional advice should be sought at once. Likewise any abnormal discharge, especially if bloody, and any persistent sore spot on lips or in the mouth or throat should receive prompt attention."

Dr. Watson reviews the statistics of cancer in New Hampshire from 1884 to 1913 and shows that there has been a steady increase in the number of recorded deaths from 210 in the first year to 453 in the last year of that period. The total number of deaths from cancer for the entire period of thirty years was 9,096. Of this number 3,075 were males and 6,021 were females. During the period reviewed the cancer death rate in New Hampshire increased from 5.93 to 10.42 per 10,000 of the population. Some

people hold that much of the apparent increase of cancer is due to more correct diagnosis and better certification and statistics, but Dr. Watson does not believe that these factors can alone account for the increase of the disease in New Hampshire.

The State Board of Health has therefore joined in the efforts which are now being made for the control of cancer by educational methods. The state laboratory has also undertaken to assist the physicians in the early recognition of the disease by examining suspected cancerous material whenever submitted.

The American Society for the Control of Cancer has undertaken to conduct a national campaign of education in regard to this disease following the example and methods of the campaign against tuberculosis. The National Society is co-operating with state and local boards of health, medical societies, women's clubs, and other organizations in order to disseminate the latest knowledge about malignant disease. If the people of New Hampshire would carefully read and take to heart the sound advice given by the State Board of Health it may well be expected that the mortality from cancer in New Hampshire will begin to show a decrease.

TO INTEREST PHYSICIANS AND NURSES IN TUBERCULOSIS.

NATIONAL EFFORT TO IMPROVE TEACHING ON CONSUMPTION AND TO HELP FAMILY DOCTORS.

For the purpose of securing more co-operation from physicians and nurses in the antituberculosis campaign, The National Association for the Study and Prevention of Tuberculosis has inaugurated a movement to bring the importance of this subject to the attention of these two groups, accord-

ing to an announcement made from headquarters today.

Among the first things which the association is trying to do is to induce the medical colleges and schools of nursing to give more instruction, particularly of a clinical nature, on tuberculosis. An effort will be made also to reach the individual practitioners and nurses by special booklets prepared for this purpose. The clinical and other facilities of the various organizations affiliated with the National Association will so far as possible be made available for the widest possible use in training doctors and nurses in tuberculosis work.

"The object of this campaign," says Dr. Charles J. Hatfield, Executive Secretary of the National Association, in making the announcement, "is primarily to secure more accurate and earlier diagnosis of tuberculosis on the part of physicians and to show nurses the great opportunities of service in the home care of consumptives. We shall also be able to put the average family physician in touch with the best methods of treating tuberculosis and with the most recent literature on that subject, thereby affording to the general public increased protection from this disease. Practically all of the medical colleges and schools of nursing of the country have expressed their approval of our plan and have offered to co-operate with us. While the medical profession generally has unselfishly assisted the nation-wide campaign against this disease, we feel because of its prevalence, tuberculosis should be given special attention by medical students and practicing physicians everywhere. No other single disease demands so much time and attention from the general practitioner in medicine. We shall try to make it easy for any doctor or nurse to acquire a specialized knowledge of tuberculosis."

NEW NATIONALISM OUTLINED AT CONFERENCE OF CHARITIES.

MORE THAN TWO HUNDRED ADDRESSES ON
QUESTIONS GROWING OUT OF THE WAR,
LEGISLATIVE POLICIES, AND FAMILY
AND COMMUNITY PROBLEMS.

Announcement has been made from the headquarters of the National Conference of Charities and Correction of the revised program of its forty-second annual session to be held at Baltimore, Md., May 12-19, 1915. The program to be contained in an early bulletin, includes the names of more than two hundred speakers. The character of this extensive series of discussions will be largely affected by social welfare legislation recently enacted in many states, by the reports of special state and municipal commissions during the winter, and by the recent emergence of many national issues of a social nature, such as have been disclosed in the investigations of the Federal Industrial Relations Commission. In addition, a growing conviction of the social bases of international amity has led to a greater definiteness in outlining fundamental issues in the United States. Hence considerable importance attaches to the subject of the keynote address of this conference, "A Prelude to Peace," to be given by the president, Mrs. John M. Glenn of New York.

Important additions to the program are a symposium on modern family ideals by Rev. Samuel McChord Crothers, D. D., of Cambridge, Mass., and Prof. James H. Tufts of the University of Chicago; a practical program for the relief of unemployment by John B. Andrews, Secretary of the American Association for Labor Legislation, New York City, and Prof. George E.

Barnett of Johns Hopkins University, Baltimore; and the "Need and Practicability of Illness Insurance in the United States," by J. P. Chamberlain of Columbia University, New York. The last two subjects are examples of a series of discussions that have been arranged reflecting in American experience problems and a need of public policy in fields that have long been the center of discussion in European countries. Considerable profit was anticipated in this respect from addresses to have been given by the late Prof. Charles Richmond Henderson of Chicago, a former president of the Conference, whose life the organization will be called upon to memorialize. One of the unique features of the program is a discussion of the work of policewomen under the leadership of Mrs. Alice Stebbins Wells of Los Angeles, to be participated in by policewomen from various cities.

The coming of the Conference is being anticipated by the city of Baltimore, which is making a survey of local social conditions to be set forth in a public exhibit. The chairman of the Baltimore committee is General Lawrason Riggs, and the secretary, Dr. J. Hall Pleasants. Preparations are being made to entertain twenty-five hundred guests. The address of welcome will be made by President Frank J. Goodnow of Johns Hopkins University.

Of scarcely secondary importance to the National Conference program are the meetings of a series of related organizations, nine of which have published programs. These include the American Red Cross, the Association of Officials of Charity and Correction, the National Federation of Settlements, the National Probation Association, the Association of Jewish Social Workers, and the Societies for Organizing Charity.

Reviews from Current Literature

CEREBRAL SPASTIC PARALYSIS.

Sharpe, Wm., and Farrel, B. P.: A New Operative Treatment for Selected Cases of Cerebral Spastic Paralysis. J. A. M. A., Vol. LXIV, 1915, p. 482.

The authors report on sixty-five cases of spastic cerebral paralysis, selected as suitable for operation from a series of 201 patients. They state that only one year has elapsed since the first operation, and hence not sufficient time has passed to say whether the improvement will be permanent or not, yet the immediate results have been gratifying and even startling.

As to their selection of cases the writers say: "Let us emphasize first, that we are *not* operating on the mentally deficient, the constitutionally inferior and idiots in the hope of restoring them to a normal mentality; and secondly, that we are not operating on microcephalic children in the belief that the brain will develop and become normal by enlarging their cranial capacity (a belief long exploded); and thirdly, that we are not operating in cases of spastic paralysis due to a lack of development and malformation of the cortex of the brain and the pyramidal tracts—cases forming at least one-half of the total number of spastic paralyses—the so-called Little's disease, in which a cranial operation will do no good, and from the very pathology of which a cranial operation can be of no benefit to the patient. On the other hand, we *are* operating in those cases of spastic paralysis giving a history of difficult labor with or without instruments, in which on ophthalmoscopic examination the definite signs of increased intracranial pressure are to be seen on the fundus of the eye; that pressure should be relieved in the hope that the spasticity will lessen and the mentality be improved."

Spastic paralysis is most frequently a result of a lesion of the brain occurring before, during, or shortly after birth. It is characterized by a hypertonicity or spasticity of the lower or upper extremities (par-

aplegia) of both upper and lower extremities (diplegia), or of one-half of the body (hemiplegia), depending on the extent of the involvement of the pyramidal tract. The paralysis or spasticity may be complete or may be so slight as to produce only an awkwardness of the part affected. As the child grows older the continued tonic muscular contractions produce deformities, of bone and tissue and, as a rule, the mentality becomes more and more impaired until the child may "be considered a defective, or still further an imbecile, and only too frequently an idiot."

But little has been done to improve, permanently, the condition of spastic paralysis, other than to correct, in some measure, the resultant contractures and deformities; hence any procedure that gives promise of cure in even a small percentage of such cases is worthy of careful consideration and trial.

The authors state that operation should be done early; the younger the child the better the prognosis; since the longer the general and local intracranial pressure exists, the greater the likelihood of actual permanent impairment of the brain cells.

"The ideal time for the operation would be immediately after birth; then, merely a small opening need be made to allow the subdural blood to flow out in liquid form with little or no resulting impairment of the cortex. However, it is extremely rare for a definite diagnosis to be made at early date—the impairment usually not being ascertained until several months later, when the child is from nine to twelve months of age."

The operation is that of decompression; a section of bone, in the temporoparietal region, from two to three inches in diameter is removed, and the dura incised in a stellate manner, allowing the brain to expand.

"The after-treatment, briefly, consists of the correction of deformities by tendon lengthenings if necessary, or merely stretch-

ings of the contracted muscles, the maintenance of corrected positions through the employment of especially adapted braces, skilled massage and faradism, particular attention being given to the weakened and overstretched muscle groups. A careful, systematic course in muscle training is carried on daily."

In conclusion the writers state that only those cases which show an increased intracranial pressure by ophthalmoscopic examination, confirmed by lumbar puncture, and give a negative Wasserman reaction with blood and cerebro-spinal fluid, are amenable to operative improvement.

R. C. T.

NEARTHROSIS.

Tubby, A. H. (F. R. P. S., Eng.): *Nearthrosis or Arthroplasty with Notes of Some Cases*. Am. Jour. of Orthopedic Surgery, Vol. XII, 1915, p. 379.

Tubby states that arthroplasty, or the treatment of bony or fibrous ankylosis by making a new joint, should be considered from several viewpoints before being performed; the age of the patient, the mental state and psychology and the physiological condition of the individual, as well as his occupation, the cause of ankylosis, the condition of the muscles and soft tissues, the extremity involved, all have a decided bearing on the success or failure of the operative procedure.

He believes that the *most suitable time for operation* is between the ages of eighteen and thirty, since this is the time that most of the remedial ankyloses occur, and because normal bone development has ceased, hence the epiphyses may be invaded without hesitation. In children the operation is usually contra-indicated, because it is ordinarily impossible to remove enough bone to refashion the joint ends without destroying the epiphyseal lines and thus impairing the growth of the limb.

The writer quotes Baumgartner's suggestion that the *psychology of the patient*

should be considered; whether the individual possesses the requisite courage and presence to undergo the necessary suffering and the more or less painful manipulations incident to the after-treatment.

The *physiological condition* is certainly of prime importance, since much depends on the ability of the patient to stand the shock of prolonged surgical procedures.

The *occupation* also enters into consideration since oftentimes a stiff, firm joint—particularly of the lower extremity—is more useful than a mobile and weak one.

It is vitally essential that the *cause of the ankylosis is extinct*; this is especially true of tuberculosis, osteomyelitis, and gonorrhœa, since in all of these conditions, operative work may open up old foci, and institute an acute process.

Finally, the nerve supply must be unimpaired, nerve trunks must be free of cicatricial adhesion, and the muscles controlling the joint must be active and strong. It is useless to confer mobility upon an ankylosed joint if there are no muscles to move it.

R. C. T.

TRANSVESICAL PROSTATECTOMY.

Pilcher, Paul M.: *The Results of Transvesical Prostatectomy*. N. Y. Med. Jour., Vol. CI, 1915, p. 283.

Pilcher reports the end results in a series of thirty consecutive transvesical prostatectomies, without death.

He comments on the relative mortality of operation versus catheter life and states that general practitioners as a class have not yet been convinced that operation is safe, because it is not generally known that the high mortality attending prostatectomy in the past has, through improved technic and the two stage procedure, been reduced to less than seven per cent.

Pilcher states that cancer develops in about twenty per cent of cases of nonoperated obstructive prostatic disease, and that there is a mortality, at the end of four years, of over fifty per cent in the cases not operated.

The operative indications are: "That relief be brought about with the least amount of risk to the patient. That the end results shall be as perfect as possible, which means that there shall be no incontinence of urine after operation; no persistent urinary fistula, and that the patient shall be free from distressing bladder symptoms."

"In approaching this problem in our work we first undertook to relieve all prostatic obstruction by means of the perineal operation. The perfected technic in this work gave us very brilliant results in comparison with those which had been obtained in previous years. In a certain number of cases, however, there were unaccountable deaths, protracted convalescence and numerous unpleasant sequelæ, which made us feel that the technic could be improved upon.

Suprapubic encucleation was then adopted, and when completed at one operation, it was found that the number of unaccountable deaths was not diminished, but that convalescence was more comfortable and the morbidity was lessened.

After the introduction of the more improved tests for determining the functional capacity of the kidney in a given case, it became quite apparent that there were two factors of great importance which influenced the recovery of these aged patients. It was early determined that the kidney was greatly affected by the urinary obstruction which caused residual urine in the bladder. This affected the kidney in a peculiar way. It stimulated it to a marked oversecretion of urine of low specific gravity and created at the same time a false index of renal efficiency. Experience showed that when the obstruction was removed and the residual urine was suddenly relieved, a most profound disturbance of the renal function took place, characterized by marked diminution in the amount of urine secreted, marked congestion of the kidney, shown clinically by the great increase in the amount of albumin in the urine, often

the presence of acute hemorrhages from the kidney, and in addition a rapid lowering of the index of renal efficiency. It was decided that it was much safer simply to relieve the obstruction to the outflow of urine as a preliminary step to the prostatectomy.

Inasmuch as we found that the prostate could be more quickly and perfectly removed by the suprapubic route, the first step in the operation took the form of a preliminary cystotomy under local anesthesia. It was also found that urinary extravasation and the infection of the space of Retz after suprapubic operations on the bladder, were due to improper technic and could be entirely avoided by using the Pezzer catheter for drainage of the bladder after cystotomy, closing the wound in layers around the catheter. The result of this improvement in technic, even in the presence of infection of the bladder, resulted as a rule in primary union around the catheter without any leakage of urine whatever. This was a very important step in advance, for with the proper healing of this preliminary wound, we had provided a track leading to the prostate which was already fortified by the protection of granulation tissue, somewhat immune to infection, and an avenue through which, in the majority of cases, the prostate might be removed without the further use of cutting instruments. Furthermore, we found that the suprapubic wounds in these two stage operations healed without the usual sloughing and long continued fistula formation, encrusted with phosphatic salts."

There was no immediate operative mortality in the thirty cases. With the exception of two cases that died of cancer of other organs during the first year, one case that developed another vesical calculus, and one that required operation for recurrent urinary fistula, all the patients were in good health at the end of their first year, and had complete urinary control. At the end of three years, twenty-three cases are recorded as normal and without bladder irritability.

At the time of operation many of the patients were in advanced stages of prostatic disease. Their ages ranged from sixty to eighty-two.

R. C. T.

ECTOPIC GESTATION.

Hartz, H. J.: The Mode of Termination in Ectopic Gestation. *American Journal of Obstetrics*, Vol. LXXI, 1915, p. 601.

Various cases are reported with photographs of surgical specimens of the different terminations in ectopic gestation.

While tubal gestation is sometimes diagnosed in the unruptured state, as a rule either rupture or tubal abortion has taken place before the diagnosis is made.

Rupture may take place at any time after conception. It may be sudden or gradual. The bleeding may take place in the abdominal cavity. Then hemorrhage is very profuse. In many such instances the patient succumbs before medical assistance is of any avail.

The tube usually does not retain the fetus beyond the tenth week; rupture or abortion being the usual termination of the pregnancy.

Hemorrhage into the gestation sac causes the ovum to perish, the sac becomes distended with clotted blood due to the eroding action of the blastodermic cells on the blood vessels, causing repeated minute bleeding into the sac, and thus forming a mole. The pregnancy, if situated near the fimbriated end of the tube, often terminates in a tubal abortion. The bleeding in tubal abortion is more gradual and less pronounced.

Primary rupture between the folds of broad ligament is not of infrequent occurrence. The bleeding is limited between the folds. The symptoms in such cases are not marked. The fetus continues to grow until a second or even a third rupture takes place before the patient comes under observation. The fetus in its progressive development becomes too large to be confined to the broad ligament and is finally extruded into the abdominal cavity. The placenta may be-

come adherent to some of the pelvic or abdominal structures. Then development goes on, the fetus obtaining its nourishment through this new attachment. This type is known as secondary abdominal pregnancy.

In not a few instances the fetus goes on to full term in these secondary abdominal pregnancies. As the time approaches for confinement some patients experience labor pains of a transient character usually associated with violent fetal movements of short duration, but as is self-evident there is not any attempt at spontaneous delivery. As weeks and months elapse past the expected period of delivery the diagnosis is changed to an abdominal tumor, usually an ovarian cyst.

If the fetus, in secondary abdominal pregnancies, remains encapsulated and is not removed by surgical means, it is converted in time either into a lithopedion or it may undergo supuration, necrosis or may become mummified.

G. R. H.

RADIUM THERAPY.

Kelly, Howard A.: Radium Treatment of Fibroid Tumors. *Surg., Gynec. and Obst.*, Vol. XX, 1915, p. 271.

Kelly presents a series of thirty-six cases of fibroid tumors treated by radium and draws the following conclusions:

Massive radium treatment of uncomplicated fibroid tumors is the best plan, as it stops the excessive flow; sometimes in younger women it regulates it without stopping it. Radium reduces the tumors in almost every instance, relieves pressure symptoms, and even causes large tumors to disappear.

A fibroid tumor is not a malignant growth; therefore any method of treatment which will give entire relief to the symptoms is the best method, provided it will at the same time avoid the various risks of an operation. If radium is tried and fails the operation can then be undertaken without any added risk. Touching this last point Kelly adds that, while a recent radium treatment often makes more difficult the sub-

sequent radical extirpation of a cancer of the cervix, there is no reason to expect this result in fibroid tumors.

It is the author's belief that, with increased experience and improved technique, it will be possible to relieve every patient of hemorrhages, and in most instances to do away with the tumor (let us say roughly speaking, in nine cases out of ten), and that without serious risk, discomfort, or confinement to bed for more than one or two days. Patients too anemic or weak even for an intrauterine application of radium can be treated through the abdomen exclusively.

G. R. H.

INFECTIOUS DIARRHOEA.

Morse, John Lovett: Infectious Diarrhoea. *Am. Journal Medical Sciences*, Vol. CXLIX, 1915, p. 17.

Infectious diarrhoea, while more frequently encountered in hot weather than at other times of the year, is essentially due to the presence of microorganisms. Hot weather acts as a predisposing factor by lowering general resistance to infection. For the scientific management of the disease, which should be largely dietary, it is essential that the causative type of microorganism be ascertained. As far as the determination of the diet to be used is concerned the causative bacteria may be divided into two groups. (1) The various forms of dysentery bacillus and the other organisms, except the gas bacillus, which cause the disease. (2) The gas bacillus and allied organisms. The "other" organisms referred to in the first group include the streptococcus and colon bacillus. The author details a method of ascertaining the presence of the gas bacillus in the stools, which method requires for its completion about eighteen to twenty-four hours.

A well-equipped laboratory is essential for determining the presence or absence of dysentery bacilli. At a given season the vast majority of cases of infectious diarrhoea are due to the same organism. Therefore while it is highly desirable to know the type of

bacteria causing the disease, if by laboratory methods the prevailing organism has been determined, then it might reasonably be assumed that this organism is also the cause in a given case.

The line of diet suitable for one type of infectious diarrhoea is not only not suitable, but absolutely harmful for another. It is extremely important not to make a mistake in the choice of diet.

The dysentery bacillus, streptococcus and colon bacillus belong to the class of facultative bacteria. They thrive on either carbohydrates or proteins, producing harmless products from carbohydrates and toxic substances from proteins. However, they act on and use up carbohydrates before attacking proteins and in the breaking down of carbohydrates they produce certain substances which inhibit the development, to a certain extent, of dysentery bacilli and streptococci. So when diarrhoea is caused by bacteria of this type the food should be largely carbohydrate in character.

Prolonged withdrawal of food is contra-indicated because the intestinal contents consist then entirely of intestinal secretions which are protein in character. The carbohydrate preferred is lactose, since it is more easily utilized by bacteria than starch, and lactose is preferable to other forms of sugar since it is slowly broken down in digestion and provides for a long time a carbohydrate medium in the intestines. Lactose should be given in a five or seven per cent solution in water at frequent intervals and in small amounts. At least as much of this solution should be given as the child would take of food under normal conditions. In from one to three days barley water should be added to the sugar diet. As soon as possible protein should be added to the diet in order to neutralize the protein waste of the body. It should be administered cautiously and in small amounts, the protein selected being whey protein or casein.

The gas bacillus and allied organisms grow rapidly in a carbohydrate medium but are

very sensitive to lactic acid. Therefore when diarrhoea is due to the gas bacillus the indications are to cut down the carbohydrates in the diet and to introduce acid-producing bacteria into the bowels. This is best accomplished by the administration of a fat-free buttermilk, milk ripened with lactic acid forming organisms. No matter what type of bacteria causes the diarrhoea fat as an article of diet is prohibited. The author advises colonic irrigations of normal salt solution once or twice daily. The so-called intestinal antiseptics have no value, nor has bismuth salts except occasionally during the chronic stage. No serum is of any value in the treatment of infectious diarrhoea.

In those severe cases accompanied by prostration and collapse and for which stimulants are needed the author recommends adrenalin, strychnia, caffeine, and camphor. Since prostration is likely to be associated with some vaso-motor paralysis and lowering of blood pressure alcohol is contraindicated.

J. D. L.

CONTINENTAL METHODS OF TREATING SYPHILIS.

Bunch, J. L.: *Some Continental Methods of Treating Syphilis*. The Urological and Cutaneous Review, 1915, Vol. XIX, p. 143.

Bunch calls our attention to the fact that the first glamour has somewhat departed from the name of salvarsan, and it is generally recognized that the drug, however powerful in relieving the symptoms of syphilis, is only capable of curing the disease in the very early stages, if at all. We are forced to return to our old ally, mercury. He further states: "We use the mercury, of course, very frequently in combination with 606, and the best results are obtained in this way, but in the end it is mercury which is our real standby in the cure of syphilis, as distinguished from the improvement, or clearing up, of syphilitic symptoms." In England, the writer thinks, the most popular method of administering mercury is by the mouth, with the iodides, while on the continent, especially at the various Spas, the inunction method is

most used; though the injection method used by a number, preference being for the insoluble salts of mercury, especially the salicylate, the injections being given deep into the gluteal muscles. In France the insoluble method has a number of followers, especially in the use of grayoil, either in the formula of Lambkin's solution, or the grayoil of the French pharmacopoeia. Both in England, France and other continental countries the soluble solutions of mercury are popular; the writer finds that the cyanide or the biniodide of mercury are the most used, both given in one per cent solution, twenty minims of the solution are injected with an ordinary hypodermic syringe deeply into the gluteal muscles, the injections are given daily, others give the injections directly into the superficial veins of the arm.

J. L. K-S.

LINGUAL TUBERCULOSIS.

Trimble, Wm. B.: *Lingual Tuberculosis*. New York Medical Journal, Vol. CL, 1915, p. 338.

Trimble in a paper read before the thirty-seventh annual meeting of the American Dermatological Association reported two cases of lingual tuberculosis, both cases questionably primary tuberculosis of the tongue. The diagnosis in case 1, though clinically clearly tuberculous ulceration, was only positively made after injection of a guinea pig; syphilis was excluded from the diagnosis both by the Wasserman test and several months' specific treatment as a therapeutic test. A biopsy showed tuberculous tissue, but no bacilli of tuberculosis were found. The writer states that the microscopical picture of the sections though characteristic of tuberculosis, are as well characteristic of syphilis, the pathological report was not accepted as final. The Moro tuberculin inunction test was performed, with a negative result, tuberculosis was not found present in any part of the body. In case 2 the diagnosis of lingual tuberculosis as a primary lesion did not present so much difficulty.

The writer gives the following conclusions:

1. The diagnosis is extremely difficult.
2. It is almost impossible to demonstrate the bacilli in the ulcer.
3. Although lues and cancer furnish the majority of ulcerations of the tongue and mouth, they are by no means the only cause.
4. In any tongue ulceration, tuberculosis must be reckoned with as a factor.
5. The histopathological examination alone is practically useless as a means of a diagnosis between syphilis and tuberculosis, but it is of great aid in excluding cancer. The majority of tuberculous ulcers of the tongue are in all likelihood secondary, but it is easy to prove that an ulcer is secondary, but to prove that it is primary is quite another matter.

J. L. K-S.

SCARLET FEVER.

Experimental Scarlet Fever in the Monkey, W. Mair, Research Pathologist to the Metropolitan Asylums Board. From the Research Laboratories of the Metropolitan Asylum Board, Lister Institute, London, S. W.

Mair mentions a number of investigators who have concluded that the monkey is insusceptible to scarlet fever. These men have placed a great deal of stress on the production of a rash followed by desquamation which, he thinks, inconclusive in that the rash is not always present in the human. The changes which appear in the staining reaction of the polymorpho-nuclear leucocytes described by Döhle, in 1912, and which by later work has been shown to add a new clinical sign in the diagnosis of scarlet fever, has been found of great value in the experimental study of the disease.

These bodies have been found in the blood of monkeys inoculated with ten c.c. of citrated blood from scarlet fever patients. Repeated experiments failed to confirm these results with scarlet fever blood, but mouth washings from typical cases produced scarlet fever symptoms with the appearance of Döhle's bodies in the leucocytes.

Various bacteria were used for inoculation, but all failed to give typical reactions except a certain diplococcus which resembles the

pneumococcus morphologically. It differs from the pneumococcus in that it has no capsule and grows in media which contains blood serum. So far the organism has been grown in human and horse serum. The organism sours milk sometime with coagulation. Acid formation takes place in lactose, cane sugar, glucose, maltose, raffinose and inulin. Mannite is slowly attacked, dulcitol and adonitol are not changed. The diplococcus is pathogenic to mice.

The results obtained indicate that scarlet fever may be due to a diplococcus which produces fever and a rash. The organism has not been found in the circulating blood. It resembles the diphtheria bacillus in that it has been found only in a limited area, the mucus membranes of the throat, and probably produces a toxin for which serum therapy may be produced. If experiments are confirmed the name *Diplococcus scarlatinæ* is proposed.

H. H.

NEW AND NONOFFICIAL REMEDIES.

Since publication of New and Nonofficial Remedies, 1914, and in addition to those previously reported, the following articles have been accepted by the Council on Pharmacy and Chemistry of the American Medical Association for inclusion with "New and Nonofficial Remedies":

ALCRESTA IPECAC TABLETS.—Tablets containing an adsorption product of ipecac alkaloids and Fuller's earth, each tablet representing 10 gr. of ipecac. The ipecac adsorption product is said to pass the stomach unchanged but to be decomposed in the intestine with liberation of the ipecac alkaloids and thus to exert the amebicidal action of ipecac in the body. Eli Lilly and Co., Indianapolis, Ind. (*Jour. A. M. A.*, Feb. 13, 1915, p. 591.)

TYPHOID COMBINED VACCINE (PROPHYLACTIC).—Marketed in vials and syringes, each package containing three doses. Schieffelin and Co., New York. (*Jour. A. M. A.*, Feb. 20, 1915, p. 665.)

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION

PUBLISHED MONTHLY

Volume I

St. Augustine and Jacksonville, Florida, June, 1915

Number 12

ORIGINAL ARTICLES

PRESIDENT'S ADDRESS.*

F. CLIFTON MOOR, M. D.,

Tallahassee, Fla.

Mr. Chairman, Fellow Members of the Florida State Medical Association, Ladies and Gentlemen:

One year ago at Orlando, you elected me President of the Florida Medical Association, and the nominal head of organized medicine in the State, and now, as at that time, I cannot find words to express to you my deep appreciation and gratitude for the honor you have bestowed upon me.

Looking back over the history of this organization and considering the number of abler men from whom I was chosen, appreciating in the highest degree the position to which you have elevated me, realizing my many short-comings and feeling deeply my own unworthiness, I come at this time to perform the last official duty of this exalted office; to relate some things which have been done and to call your attention to other tasks which now confront us and to assure you that the confidence you have shown in me has strengthened my resolve to devote myself more unselfishly to the upbuilding of our organization and to the general advancement of our profession.

The Florida Medical Association was organized in Jacksonville in 1813. The membership has grown, but perhaps not so rapidly as to keep pace with the wonderful progress of our State. The establishment of an official Journal for the Society has and will aid in bringing into the ranks many

who simply from carelessness have ignored their own as well as the interests of the Association. The Journal, now less than one year old, has been well edited and excellently managed and deserves our heartiest support. We should see that all news items of interest to the fraternity as well as all worthy scientific papers, read before the several County Societies, be sent to the Journal for publication. It helps the Journal and more especially it helps us, and tends in every way to bring our membership in closer touch with each other.

The strength of the profession as isolated individuals is multiplied many times by organization, therefore let me urge that during the coming year a strong campaign for increase in membership be inaugurated.

A new era has dawned in the relationship between the physician and the public. We are no longer looked upon as mere caretakers of the sick. The wonderful advances in hygiene, the active work of Boards of Health and the constant crusade against preventable disease has added to our many other duties, that of teacher.

A few years ago no physician could talk to a lay audience on a medical subject without being criticised. Now, through the various County, State and National Associations every means of education is called upon. The press and the pulpit, the lecture platform and the moving picture show, are all aiding in spreading the gospel of good health, but back of every one of these agencies, the originator, the organizer and the active supporter, stands organized medicine.

The men of our profession should be proud of the fact that every step forward in the fight of man against disease, every

*Delivered before the forty-second annual meeting of the Florida Medical Association at DeLand, May 12-14, 1915.

great advance in the propaganda of public health, has been made by self-sacrificing physicians, and further, that it is the constant educational work of the conscientious doctor, in the school, in the home, in the halls of our legislature, that is bringing the negligent public to a realization of the practical value of prevention.

The progress of science in all of its branches during the past quarter of a century has been most noteworthy.

The present conflict in Europe is demonstrating most vividly the advance that man has made in the art of war. It will be my privilege at this time to briefly call your attention to the other side of the ledger, the credit side, the entries on which may be counted on to balance even this great destruction of human life.

One by one the preventable diseases have been brought out from the shadows of mysticism and superstition into the clear light of pure science. The earnest efforts of the laboratory and research worker, the clinician, and the hard working general practitioner are bearing fruit. The mortality of tuberculosis has been reduced from two hundred and twelve to one hundred and forty-seven per hundred thousand population within the past twenty years, the possibility of typhoid prevention by vaccination has become an assured fact within the past five years. Diphtheria is no longer the dread disease of childhood. Antitoxin has reduced its mortality from forty-five to less than seven per cent, and now we are informed that a very simple test has been discovered by which we may ascertain at any time whether a particular individual is susceptible to diphtheria or not.

Bubonic plague is counted among man's vanquished enemies. In New Orleans last year, without quarantine, without interference with business or commerce, and absolutely without panic, a systematic and scientific warfare against the rat and his unwelcome guest, the flea, and, what might have become a scourge to the whole nation,

was overcome with a loss of only six human lives. Incidentally, there were something over three hundred thousand rats brutally slaughtered.

The dread of yellow fever, which hung like a pall over our southern cities for a century, has passed with the mists of yesterday. The labor of many workers and the sacrifice of one of our noble army surgeons and yellow fever ceases to be the mystery of miasms.

Malaria and yellow fever, the twin demons of the tropics, which for ages have guarded the richest circle of the globe and made it uninhabitable for the white man, have both been changed by the eye of science into minute infective agencies, borne by the weakly mosquito, and against which the only weapons needed are drainage, coal oil and fine mesh wire screens.

And finally, we are assured by work done during the past year that, those of the present generation, will not have to look forward to a toothless old age. Riggs disease has been vanquished at last.

Within a single generation signal progress has been made in our knowledge of typhoid fever, bubonic plague, tuberculosis, typhus fever, diphtheria, meningitis, malaria, yellow fever and the various digestive diseases of infancy, and the practical application of this knowledge has added over twelve years to the average life of our citizenship.

What may be done in the next generation is beyond human foresight, but the splendid work of Gorgas in the Isthmus has demonstrated that the enforcement of known hygienic and sanitary laws can make even a pest hole into a health resort.

In the field of diagnosis the improvements in roentgenology, the Wasserman and Noguchi reactions, the Luetin test and the various complement fixation phenomena are all more or less recent and are enabling us to give more efficient service.

Therapeutics, too, is fast getting away from empiricism and dogma. The Coun-

cil of Pharmacy of the A. M. A., is giving us the benefit of a thorough investigation of the physiological action of all drugs and compounds, and the addition of the various glandular extracts and autogenous vaccines has added much to our armamentarium.

Florida is blessed with excellent public health laws, a well maintained State Board of Health, and a most efficient State Health Officer. No state does more for her people and her physicians. Few of us realize the many services and various activities of the Board. Through its hookworm campaign, its fight on tuberculosis, its maintenance of laboratories, its free antitoxin to indigents and smallpox vaccine to all, its visiting nurses and its ever-ready corps of able assistants, the Board is our constant aid and should receive the commendation and hearty co-operation of every member of the profession. The present Legislature has passed several additional health bills which will materially increase the usefulness of the Board, and the Florida Medical Association as an organization and as individuals should always stand ready to co-operate with and uphold them.

In view of the rapid progress in state medicine and the general interest of the profession in this subject, I would suggest that the program committee arrange to have a symposium on public health questions at each succeeding meeting of the Association, the contributors to be from among the various city and state health officers and laboratory workers.

For the past several years each retiring President has called your attention to our medical practice act, or the lack of one, and urged the formation of a composite Board of Medical Examiners with uniform standard of requirements for licensure. Such a bill is now in both branches of the Legislature and, while no man can foresee what a petty jury or the State Legislature will do, we, who have been on the ground, feel encouraged as to the prospects. In

this connection let me call your attention to the earnest work of your Legislative Committee who have had charge of drafting the bill and who have conducted the fight thus far.

State after state has enacted new medical practice acts in keeping with modern conditions and requirements. The medical colleges are yearly raising their standards or are being absorbed by other institutions and now Florida, under her present system, will rapidly become a dumping ground for ineligibles from other States. The bill now before the Legislature would give us a strong law and the united profession of the State can see that it becomes a statute.

Florida has acknowledged its obligation to the indigent insane by the establishment and maintenance of a State hospital for their care. Our commonwealth has at this session of the Legislature appropriated the sum of \$125,000 for the eradication of Japanese canker, a plant infection which threatens our citrus fruit industry, and is spending \$20,000 per annum for the treatment of hog cholera. Our State has also appropriated the munificent sum of \$15,000 for the benefit of its crippled and ruptured children. We have recognized the need of State aid in the care of our plant life, our swine, our deformed children and our insane; why should we not have the same consideration for our unfortunate brother whose illness is physical, rather than mental; why should we discriminate in favor of the crippled child and leave the father or mother to go through life a chronic invalid for the lack of some needed operation, or die because of their inability to get proper sanitarial treatment during acute illness? Why should the child who is deformed or maimed be cared for, and the one who suffers from some other pathological condition be neglected?

In my opinion the State owes it to her indigent sick, no matter what their particular ailment may be, to build and maintain hospitals for their treatment.

This subject was discussed at the Orlando meeting and the suggestion was made that a bill be drafted authorizing the various counties to bond for the erection and operation of county hospitals, but the fact confronts us that the poorer counties, the counties really most in need of charitable institutions of this kind, would be the last to establish them. The medical profession of Florida stands ready to give its services. The State that can give \$150,000 for the conservation of her fruit trees and live stock can surely afford a like amount for the preservation of her citizens.

SURGERY OF TODAY: ITS IDEALS AND ITS ACTIVITIES.*

GERRY R. HOLDEN, M. D., F. A. C. S.,
Jacksonville, Fla.

In the days before the discovery of anaesthetics and before the knowledge of laws of sepsis, operative surgery was used only as a last resort for the most distressing and dangerous conditions. Almost every operation was so dangerous and horrible, that surgical methods were dared only when the danger and suffering from the disease overshadowed the risk and agony of the operation itself.

Surely the surgery of those days called for surgeons cast in an heroic mold. Of inflexible courage, undaunted by the horrible agony which he inflicted on his patient, the surgeon possessed, in addition to a wealth of anatomical knowledge a degree of manual dexterity and rapidity of movement rarely found in our surgeons of today.

He was pre-eminently a man of action, a man who did things, and a man who believed in doing them. Rarely was he a philosopher, an original thinker or an investigator. Almost never had he any marked diagnostic ability, his operative

indications were usually plain and simple, his methods quick, direct, and brutal.

Today the average layman's conception of a surgeon is not far removed from this figure of former days. To the public, the surgeon is first of all a man who cuts. Viewing all things from a surgical standpoint he finds in every patient who consults him some excuse for operation. Hardened and callous, he has little or no regard for human suffering. Often, it is suspected, he has little regard for human life itself as compared with his love for human vivisection. The good results which he obtains he achieves solely through his manual skill. He is in fact a high grade artisan, a carpenter in human flesh.

While it may be true that such a distorted conception of the modern surgeon is not held in toto by many intelligent laymen, it is nevertheless a fact that not only many of the most intelligent of laymen, but also some physicians, have a very imperfect comprehension of the ideals and activities of the surgeon. His more important attributes are minimized, while the relatively unimportant ones are overestimated.

Since the advent of anaesthesia and antiseptics, operative discomforts and dangers have been enormously lessened. The field of surgery has increased many times in extent. The conditions of operation today are absolutely different, and an entirely new type of surgeon has been developed.

Let us consider what surgery actually is. Roughly speaking, surgery is that branch of medicine in which certain diseased conditions are relieved by operative procedures. This concept implies two distinct premises: first, a recognition of the diseased condition; and second, the means of obtaining its relief. To the patient, the second of these premises is the only one of importance. Really it matters little to him what the condition so long as he obtains relief from his suffering.

To the surgeon, however, the first premise is usually far and away more important

*Oration delivered before the forty-second annual meeting of the Florida Medical Association at DeLand, May 12-14, 1915.

than the second. The treatment of any abnormal condition is entirely dependent upon a recognition of the disease, therefore the thorough surgeon of today is pre-eminent a diagnostician.

In diagnosis, medical art rises to its fullest and highest development. The skilled diagnostician must possess, in addition to an inexhaustive knowledge of general medicine and a thorough scientific training, a mastery of the modern methods of exact diagnosis, and an ability to make accurate deductions from careful observations. All his senses are developed far above those of the average man. Intellectually, he is representative of the keenest minds in medicine.

After the existence of a certain abnormal condition is recognized, the conscientious surgeon does not immediately advise some particular operation. He has no stereotyped procedure which he always advocates in cases of certain type. Rather, he analyzes each individual case and tries to decide what would be the best treatment for that particular patient.

Before it can be said that any operation is necessary, three conditions must be satisfied beyond reasonable doubt. First, we must be satisfied that the symptoms of which the patient complains are caused by the condition on which we are going to operate. Second, we must have a reasonable assurance that these symptoms will be either entirely relieved or greatly benefited by the operation which is proposed. Finally, we must be reasonably certain that the probable danger from the operation itself, when compared with the severity of the lesion and expectation of relief, is small enough to justify the patient in taking the operative risk.

Before the surgeon can feel that these conditions are satisfied, the individual case must be viewed from every angle. The age of the patient, his general physical condition, the presence of any other diseased conditions, are all of importance. Also the

degree of operative risk which can be run is profoundly modified by the needs of the patient and the gravity of the lesion. It is only after consideration of these, and many other details, that the surgeon decides whether or not operation is desirable.

While operative technique itself is of less importance than diagnostic ability, it must not be considered of little moment. Operative skill and dexterity, the ability to foresee and avoid difficulties, is of course most necessary to the successful surgeon. It is difficult at times for even a physician, and always impossible for a layman, to properly estimate the operative ability of a surgeon. Few lines of human effort can be more spectacular than the technique of some operations, and yet some of those procedures which are most startling to the spectators are really ridiculously simple to the initiated.

The value of speed in operating is greatly misunderstood. Before the days of anaesthesia the quickest operator was as a rule the best surgeon. Today the man who, spurred on by vanity, exerts all his efforts to obtain a reputation as a "lightning surgeon" is certain to act to the detriment of many of his patients. Only in an occasional desperate operation must all other considerations be sacrificed to the element of time. A few additional minutes of anaesthesia as a rule adds nothing to the operative risk, while ten or fifteen extra minutes of careful work may make the difference between an uneventful recovery and some horrible post-operative complication, or even death itself.

Haste in surgery is more frequently needed before the operation. A perforated appendix, a spreading peritonitis, a ruptured extra-uterine pregnancy, these and similar conditions all demand the utmost haste from the time the patient is first seen, until he lies on the operating table ready for the incision. To attain rapidity of diagnosis in such cases, to be able to recognize at once the "surgical

abdomen" which, no matter what be the lesion, cries most urgently for operation are goals to which every true surgeon strives his utmost.

As in every other line of human effort, we have all sorts of surgeons—good, bad and indifferent. The desire to be an actor in the bloody drama of the operating room sometimes draws low-grade men, who see in surgery only an opportunity to gain notoriety, or to enhance their reputations as surgeons among the laity. The popular delusions regarding the large incomes which surgeons are supposed to receive often attract a class of commercially inclined physicians. Naturally with such men, the best interests of the patient are never considered. Fortunately for the public, they rarely, if ever, rise to scientific prominence in their profession.

More frequently is the ambitious young doctor or student drawn to surgery by the opportunity which it offers him to do things that get results. The methods of medicine are often slow and uncertain. Surgery offers us a medium by which we may obtain results at once, and results about which there is no doubt. Thus to the energetic, resourceful young man, desirous of doing all that he can, impatient of slow and uncertain methods, surgery makes a powerful appeal. Of such probably are the rank and file of our profession composed.

Here and there we find a thorough surgeon, a man of broad philosophical mind, a deep thinker, an original investigator, a careful and skillful operator. Of such are the great surgeons made.

As the average surgeon's experience increases, and as he gets a grasp on his work as a whole, he gravitates, unconsciously perhaps, toward one of two groups. He becomes finally crystalized as either a conservative or a radical. Each class has its strong points and its weak ones. Conservatism certainly tends toward safety. The conservative man knows when to stop.

He considers more carefully his individual patient; he makes him better if he can, but at all events he never makes him worse. On the other hand he has vast respect for received authority; he rarely enters new fields; he brings few additions of any great value to surgical knowledge.

The radical, however, is the restless, inquiring mind. Never content with old methods, he is always striving for novelty. He thinks perhaps more of his art in general than of his individual patient in particular. He achieves at one time the most brilliant, wonderful successes. The next day his methods may bring him to most terrible and tragic mistakes. But to the radical mind are due the advances of surgery. He is the pioneer, the investigator. Ignoring the sneers of his slower witted confreres, disregarding the weight of authority against him, with his ingenious mind and dogged will he blazes out the trail which the rest of us must follow.

Conservatism tends toward modesty; the radical toward vanity. Either extreme is dangerous, yet it is most important that the surgeon be able to objectively study and analyze his own work. His own self-respect and self-confidence are strengthened when he knows that he is doing things well. Even more important is it for him to recognize faults or errors in judgment. Only by this acquired faculty of self-analysis can he hold fast to that which is good, and rectify that which is bad.

Inasmuch as our diagnoses are so much more nearly accurate, and good results so much more apt to be obtained than formerly, so can the surgeon adopt a more frank and open attitude toward his patients. Ignorance and uncertainty do not compel him, in order to keep the confidence of his patients, to "look wise and say nothing." It is for his advantage to tell the truth to his patients. Even if a surgeon's lie is never discovered by the patient himself, there are usually others to whom the fact of that lie is known. Never

in the future will they have the absolute confidence in the doctor's statements, which is often such a great factor in either medical or surgical treatment. Frequently friends or relatives are afraid that knowledge of the truth will have a depressing or unnerving effect on the patient. Experience, however, proves the opposite. As a rule, unpleasant truths are borne with much greater fortitude than most people imagine. The more the surgeon avoids lies and insists on telling the truth, the greater good will he be able to do his patients.

The surgeon's life is in no sense an easy life. The financial rewards are infinitely less than popularly supposed. The financially productive period of a surgeon's career is limited at the best to twenty or twenty-five years. In preparation for these years he has devoted time, energy, and money, which if directed toward business pursuits would have brought a financial return much larger than he could ever expect in surgery.

He lives a life of endless care and toil. Day after day both physical and nervous energies may be strained to their utmost, yet no matter how near the breaking point he actually is, his faculties must always be alert and his judgment clear. At any moment he must be ready to accept the greatest responsibilities. The greater the danger the more confusing the unexpected crisis, the calmer must be his spirit and the steadier his hand.

School himself as he will, the conscientious surgeon always worries about his patients. If he does not worry he does not care, and the surgeon who does not care is lost. Da Costa relates that once the elder Dr. Gross operated, before his students, upon a beautiful golden-haired boy. The next day some one said, "Professor Gross, how is that pretty boy on whom you operated yesterday?" Gross raised a stern, set face, "That child is dying," he

answered fiercely, "and I wish to God I had never been a surgeon."

He must be equally unaffected by praise or blame, one is usually as undeserved as the other. No man can take credit to himself for simply doing well that which it is his duty to do well. If we allow our vanity to be flattered by praise which we know we do not merit, what defense have we against the undeserved criticism or slander which some day is bound to come?

Great as are the trials of a surgeon, anxious and exhausting as is his shortened life, the reward is meted out in like manner to the true, earnest, conscientious man. Not in money, not in appreciation, nor in gratified vanity; not in public position, nor even in the hearty plaudits of fellow surgeons. His reward comes from the inner consciousness that he is doing well that which God put him in the world to do, and that, with God's help, he is making people better and happier.

Nothing can make the soul of the surgeon happier than to feel that, now and then, he happens to be the one man which saves the life of which all others despaired.

To face a sudden crisis, an unexpected terrifying complication, and to find the way out by sheer force of will and nerve, is a triumph for the surgeon. And what must it be when, after long weeks or months of study and research, the surgeon realizes that he has finally discovered some one principle, some theory, or some method that simply in place of saving just one life, will enable all other surgeons in the future to save countless numbers of lives?

Surgery is sensational. Surgery is flamboyant. It receives now a fulsomeness of praise, which it does not merit; and again a lashing from malice or ignorance, which it does not deserve. Its devotees, lashed to its iron wheel, are soon strained in its service and become old and broken before their time. Yet not one of them who earnestly and conscientiously strives to do his

best by his patient, his art, and himself, who does not reap a reward comparable in its richness and fullness with nothing else on earth.

PROPAGANDA FOR REFORM.

PEACOCK'S BROMIDES.—A report of the Council on Pharmacy and Chemistry points out that Peacock's Bromides (The Peacock Chemical Co.) said to contain the bromides of potassium, sodium, ammonium, calcium and lithium equivalent to 15 grains of potassium bromide per fluid dram, is secret in composition in that the amount of the individual bromides is not stated. The report contradicts the asserted uniformity of the preparation and the claim of superiority. It questions the asserted advantage of a mixture of bromides over a simple bromide solution and holds that, if there were any advantages in prescribing such a mixture of bromides, the physician should regulate their proportions. The report further points out that the therapeutic claims are misleading and not in accordance with modern teachings and practice. Thus while the Peacock company advises the liberal use of bromides in the treatment of epilepsy, the best clinical teaching advises the avoidance of bromides as far as possible. (*Jour. A. M. A.*, April 3, 1915, p. 1177.)

CHIONIA.—A report of the Council on Pharmacy and Chemistry discusses the claims made for Chionia (The Peacock Chemical Co.) said to be "A Preparation of *Chionanthus Virginica*"—a drug which is generally conceded to be worthless and which has been the subject of an unfavorable report of the Council. While claiming Chionia to be a "potent hepatic stimulant" the exploiters appear to appreciate its inefficiency, for it is advised to combine the nostrum with drugs of recognized potency such as the heart tonics and laxatives in passive congestion of the liver, mercurial purge, podophyllin or sodium phos-

phate in "Biliousness," etc. (*Jour. A. M. A.*, April 3, 1915, p. 1178.)

DR. MAY'S FORMULA.—Dr. May's Formula, formerly called May's Epilepticide, is sold on the mail order plan by Dr. W. H. May Medical Laboratory, New York. Examination in the A. M. A. Chemical Laboratory indicated that this "epilepsy cure" contains ammonium bromide and sodium bromide as the essential constituents, the bromide content being equivalent to 15 grains of potassium bromide per fluidram. (*Jour. A. M. A.*, April 3, 1915, p. 1178.)

HAGEE'S CORDIAL.—The Council on Pharmacy and Chemistry reports that Hagee's Cordial of the Extract of Cod Liver Oil Compound (Katharmon Chemical Co.) has neither the nutritive qualities nor the reconstructive efficacy of cod liver oil and that it is worthless for the conditions for which it is advertised. Recent experiments having shown that cod liver oil, like butter and egg yolk, possesses certain growth-promoting properties not found in some other fats, the promoters of Hagee's Cordial claim these properties of cod liver oil for their extract. The Council has previously expressed the opinion that cod liver oil owes its value in the main or entirely to its fatty constituents. Now the Connecticut Agricultural Experiment Station has demonstrated that the growth-promoting properties of cod liver oil are not to be found in Hagee's Cordial. (*Jour. A. M. A.*, April 10, 1915, p. 1262.)

WAMPOLE'S PREPARATION.—Wampole's Perfected and Tasteless Preparation of an Extract of Cod Liver (H. K. Wampole Co., Inc.) is marketed under a non-quantitative and therefore practically worthless statement of composition. Experiments carried out at the Connecticut Agricultural Experiment Station have demonstrated that the Wampole Preparation, which also contains extract of malt and sugar, does not possess the advantages over ordinary cod liver oil as a source of nutriment, as

claimed. Neither did the Wampole preparation appear to possess to any marked degree the reconstructive properties of cod liver oil, butter fat and egg yolk. The Council on Pharmacy and Chemistry held Wampole's Perfected and Tasteless preparation of an Extract of Cod Liver ineligible for New and Nonofficial Remedies because contrary to claim, it lacks both the nutritive and reconstructive properties of cod liver oil and because it is marketed under an indefinite name and under unwarranted claims. (*Jour. A. M. A.*, April 10, 1915, p. 1262.)

THE ELECTRO-CHEMICAL RING.—A post office fraud order has put a stop to the sale of this silly contrivance. This ring, put on the market by the Electro-Chemical Ring Co., Toledo, Ohio, was found to be made of ordinary iron. It was claimed to cure diseases caused by acid in the blood, among which were stated to be Bright's disease, diabetes, epilepsy and cataract. (*Jour. A. M. A.*, April 10, 1915, p. 1263.)

DR. CRONEY'S SPECIFIC FOR EPILEPSY.—This epilepsy "cure" is sold on the mail-order plan by Dr. James T. Croney of Columbus, Ohio. Examination in the A. M. A. Chemical Laboratory showed it to be a solution containing ammonium bromide and potassium bromide as essential constituents, containing bromide equivalent to 16.9 grains potassium bromide per dose of two teaspoonsful (2 fluidrams). Like other epilepsy "cures," Croney's Specific for Epilepsy is a bromide mixture and is both worthless and dangerous. (*Jour. A. M. A.*, April 17, 1915, p. 1344.)

THE QUALITY OF BLAUD'S PILLS.—Examination of the various brands of Blaud's Pills supplied by manufacturing houses, made in the A. M. A. Chemical Laboratory, refutes the commonly assumed instability of ready made Blaud's pills. On the other hand it is shown that the Blaud's pills on the market are not very reliable as to the amount of iron present, the variation ranging from 77 to 183.2 per cent. of the

claimed amount of ferrous carbonate. The different brands also differed widely in their ease of disintegration. The special forms, such as the "nascent" preparations, the "soft mass" pills and the gelatin encapsulated oily suspension, sold as "Frosst's Blaud Capsules," showed no advantage over the ordinary kind. (*Jour. A. M. A.*, April 17, 1915, p. 1344.)

LACTOBACILLINE OMITTED FROM N. N. R.—The Franco-American Ferment Co. is offering its Lactobacilline preparations direct to the public. The company has distributed circulars in which the public is informed that auto-intoxication is the cause of innumerable ills, that the Bulgarian bacillus is a "wonderful corrective or remedy" for such conditions and that the Lactobacilline products are, by inference, the only reliable products. In view of the action of the Franco-American Ferment Co. and the tendency to cause the public to exaggerate slight ailments into alarming conditions, the Council on Pharmacy and Chemistry has deleted the Lactobacilline products from New and Nonofficial Remedies. (*Jour. A. M. A.*, April 17, 1915, p. 1346.)

OLIVINE.—Olivine was a liquid soap put on the market by the To-Kalon Manufacturing Co., Syracuse, N. Y. It was declared misbranded under the Federal Food and Drugs Act because, contrary to claim, it was not made from olive oil, because boro-glycerine was absent and because it had neither antiseptic or germicidal action. (*Jour. A. M. A.*, April 17, 1915, p. 1346.)

FRECKLELESS.—Freckleless, J. E. Barry, Paris, Texas, was sold for the removal of freckles, sunburn, tan, etc. It was found to be a petrolatum ointment of bismuth subnitrate and ammoniated mercury. Freckleless was declared misbranded under the Food and Drugs Act because it was not harmless as claimed and because it was not a skin food, as claimed. (*Jour. A. M. A.*, April 17, 1915, p. 1346.)

Proceedings of the Forty-Second Annual Meeting of the Florida Medical Association, Held at DeLand, May 12-14, 1915

WEDNESDAY, MAY 12, 1915.

The General Association was called to order at 11 a. m., by Dr. John MacDiarmid, Chairman of the Committee on Arrangements. After the invocation delivered by the Rev. H. C. Colebrook, pastor of the First Baptist church, Dr. John MacDiarmid delivered the following address of welcome on behalf of the city of DeLand:

"Mr. President, Members of the Florida Medical Association, Ladies and Gentlemen:

"In the name and in behalf of the city of DeLand, I welcome you.

"Whatever our duties or relations in life may be we all come, now and then, to certain passes where all is pleasant and sweet so that the halo which surrounds us for the time being effectually dispels the clouds that would otherwise darken our pathway through disagreeable experiences.

"The duties of a mayor are many and varied, even as the duties of a physician are many and varied. Since I have been in office I have had to do many things that I would much prefer not to do, but duty is relentless in her requirements, and I have pretended to take pleasure in doing duties that were very disagreeable to me.

"But this morning, ladies and gentlemen, the pleasure of welcoming you to our little city outweighs all the disagreeable experiences of my official career. Personally, I welcome you as brethren, who have conferred upon me as one of your members, all the honor within your gift; as chief executive of the Athens of Florida, I welcome you to one of the prettiest, cleanest and healthiest of Southern cities. Thus, in the double capacity of physician and mayor, I can reach out, as it were, and greet you with the intimate grip of professional fellowship,

and welcome you with the glad smile and hearty handshake of loyal and hospitable citizenship. And this I do, ladies and gentlemen, I greet you and welcome you to DeLand of delight.

"Now, who are we that should be honored with your presence? We are the people—the city of DeLand, about five thousand in number, becomingly modest in the matter of proclaiming from the hill-tops our advantages over many of our sister cities, clean as to reputation and character, with no grafters in the city government, no saloons, nor houses of ill-fame, nor marshes, nor undrained acres within our borders, no malaria nor typhoid worth considering, and there is a united and determined effort being made to have no mosquitoes nor flies.

"Like one of the cities of old, we sit enthroned upon seven hills, and, facing the noonday sun we may thrust our right arm through five miles of fragrant citrus groves to the majestic St. Johns river, bearing upon its bosom magnificent steamers in daily contact with the travel and commerce of the world, and with our left hand we fan ourselves with ocean breezes filtered through twenty miles of primeval pine forest.

"We have fourteen churches (not that we really need so many, but we are a church-going people), twelve different charitable or benevolent organizations, several Greek Letter fraternities, an excellent public school—a solid stone in the bulwark of our national liberties—and a great university, the peer in many respects of much older and larger institutions of learning.

"We have several ornamental wood-work manufacturers, and do you realize that you are today standing in the midst of the greatest tangerine growing sections of the whole country, perhaps of the world?

"We have a press equal in enterprise and progressiveness, indeed, I may say more progressive and enterprising than any in the state. Proof of this claim will be submitted to you every day during your visit. But why enumerate more of our advantages?

"Now, on the other hand, who are you that such a city as ours should welcome you?

"You are the alpha and omega of our lives, inasmuch as you are the ones who gladly usher us into the world, and ultimately, with great reluctance, help us when we are going out of it.

"You are the welcomed comers into the luxurious halls of the millionaire as well as to the temporary abode of the injured hobo. You are the father-confessor of the wayward and the staunch support of the reformed. You are the trumpet-voiced watchmen on the towers to warn us of dangers, individual and national, and the safe repositories of our greatest secrets. You are the men who work unreservedly and unweariedly to deprive yourselves of work. You are the representatives of a profession with a past glowing with faith, hope and charity, benevolence, patriotism and heroism, with a present keenly alive to the needs of erring mortals and suffering humanity, and with a future glorious with possibilities and evolutions that no one can calculate. You are humble but proud and independent American citizens who rejoice at discoveries and inventions which bring peace and comfort, and banish pain and suffering and grief, in contra-distinction to the kings and emperors and princes of Europe who, to gratify primordial passions and lusts, are saturating a continent with blood, and thus hurling back into savagery centuries of civilization and Christianity. Although your life work is to go about doing good, yet, if it so be, which God forbid, that our national liberty or honor should suffer at the hands of effete European monarchies, and Old Glory should be unfurled to vindicate the cause of justice and right, I am sure that some of the mem-

bers of the Florida Medical Association would bravely and cheerfully follow the flag. But, at the same time we know that:

"If you but had the power to stay the blighting hands of pain and sorrow, the human hearts that wilt today would lift their heads and bloom tomorrow."

"You are the worthy successors of the good old-fashioned family doctor that we are fond of picturing with the vegetable kingdom in his right hand, the animal kingdom in his left hand, the mineral kingdom strapped upon his back, and the whole human family lovingly couched in his capacious lap.

"Now, ladies and gentlemen, this city on the one hand, and you on the other, being as I have briefly sketched, it seems to me that kindred spirits have met, and that as this is the largest meeting in your history it should also be the best. The city is yours while you are here, therefore, enjoy yourselves. However, I might say, in behalf of the local physicians, that, no matter how well you may like our town, we hope that none of you will remain here permanently to practice medicine.

"I know that you and the druggists everywhere are first cousins, and when you go into a drug store here if you want to be waited on with promptness and efficiency, just address every one connected with the drug store as "Doctor" and you will have faultless service.

"Please bear in mind, gentlemen, that, while the city jail is on one side and the county jail on the other side of our meeting place, if you get into trouble with the police or any one else, insist on being tried in the Mayor's court *first*, and I, having a fellow feeling for you, assure you that if any one is punished it will be the policeman or the plaintiff. In other words, while you are the guests of the city you may do just as you please.

"Again, ladies and gentlemen, let me say that DeLand is glad you have come here, is

proud of your presence, and heartily welcomes you."

Dr. L. B. Bouchelle, of New Smyrna, representing the Volusia County Medical Society, stated:

"Mr. President, Gentlemen of the Association:

"There is no community in Florida but would feel a sense of gratification with the presence of a body of gentlemen so distinguished as honors our community today. In behalf of the Volusia County Medical Society it is a pleasure to welcome you to the Athens of Florida—not in a spirit of mere formality but cordially and heartily.

"Here in this city, the home of a splendid institution devoted to the higher ideals of education, you will find a spirit of sympathy and understanding of the high aims and purposes of our profession.

"These people appreciate the value and necessity of a thorough scientific training for members of the medical fraternity and do not approve of the 'unskilled tampering with human ailments' so common in other cities.

"The Volusia County Medical Society sympathizes freely with the aims and objects of your visit and our sincerest wish is that your stay will prove as pleasant to you as it is welcome to us.

"Again I bid you welcome."

Mr. S. D. Jordan, representing the Business Men's League of DeLand, said:

"Members of the Florida Medical Association, Ladies and Gentlemen:

"I wish to welcome you, Mr. President and members of the Florida Medical Association, to our city, on behalf of the DeLand Business Men's League, and we trust that the sessions of your association while here will be pleasurable ones as well as beneficial; and when after adjournment you have gone to your homes, that you take with you a memory of DeLand and her people that you can always recall with

pleasure, and we hope, gentlemen, that it may be our good fortune, at some time in the future, to again welcome you to DeLand."

Mrs. W. R. Stephens gave a brief address in behalf of the Woman's Club.

President Lincoln Hulley, in behalf of Stetson University, gave the following welcoming address:

"Mr. Chairman, Members of the Florida Medical Association, Ladies and Gentlemen:

"On behalf of the university I welcome you warmly to DeLand. Judging from the amount of rain that we have had since you arrived here you might think that you are being welcomed to DeWater and not to DeLand. But it is a welcome to DeLand and we can not help the weather. If any of you are worrying about the weather, give out the statement of Riley, 'It haint no use to grumble and complain, it's jest as cheap and easy to rejoice; when God sorts out the weather and sends rain, why rain's my choice.'

"While you are in DeLand we want to welcome you at the university. We will be glad to have you visit our laboratory.

"We are trying to give to students who take our college course a preliminary study in medicine; that is, physiology, splendid chemical laboratories, well equipped for the study of bacteriology and zoology, and everything in the course of medicine that will be needed by a student who wishes to pursue his studies at a medical school; he can do at least one year's course in medical science.

"Next door to Dr. Fisher's drug store is now an exhibit of the State Board of Health. The university invites you to go in to see this exhibit. One of our doctors, Dr. John MacDiarmid, went to Jacksonville some time ago just to see this exhibit when given there.

"Again I extend to you in behalf of the university a warm welcome to our city."

Dr. F. C. Moor, President of the Association, gave the following address of response in behalf of the Association:

"Mr. Chairman, Members of the Volusia County Medical Society, Ladies and Gentlemen of DeLand and all who have had any part in this warm reception:

"I want to express to you all the most heartfelt appreciation of the members of the State Medical Association for your welcome.

Last year at Orlando, as a delegate from the Leon County Medical Society, I had the pleasure of extending to the Association an invitation to meet with us in 1915 in the Capital City, explaining that there would be some important medical bills coming up before this session of the legislature and that the presence in Tallahassee of this representative body would help us greatly in carrying through the enactment of our much-desired Medical Practice Act. The argument was sound and the invitation was heartily indorsed by members from all sections.

"For a few minutes it looked as if Tallahassee would carry the convention by storm, but just at that critical moment there arose on the extreme left a gentleman with the figure of Apollo, the brow of Jove and the oratory of Demosthenes. He explained in a short but beautiful address why DeLand was the only city in the state which was really entitled to the next meeting of the Association, and in conclusion read a telegram which was longer than his speech, extending an invitation from the city of DeLand, the Press of DeLand, the Volusia County Medical Society, the Chamber of Commerce, the Woman's Club, and signed by the Mayor of DeLand (the Honorable John MacDiarmid, M. D.).

"Needless to say this speech stampeded the convention.

"We are glad to be with you. We appreciate every word that has been said by the

representatives from the various organizations that have welcomed us. These meetings are always enjoyable in the opportunity afforded to renew old friendships and to make new ones, and at this meeting your guests are especially fortunate in having among the addresses of welcome such kind words from the ladies.

"In behalf of the Florida Medical Association let me say that we congratulate ourselves on being accorded the privilege of seeing your beautiful city and meeting its most hospitable citizens."

To the President and Members of the Florida Medical Association:

GENTLEMEN—At the Forty-first annual meeting of the Florida Medical Association there were reported twenty-six county societies organized with a total membership of 466. During the present year we have added to our membership fifty-eight new members, the total membership reaching 524. There have been reported up to the present time twenty-six counties, with a total membership of 431. At the time of writing this report the following counties have not forwarded their reports: DeSoto, Holmes, Osceola, Putnam and Suwanee. Several of the counties having already sent in a report state that additional members will forward their dues within a short time. While the gain in membership for the past year has not been as large as we might hope for, it is probably satisfactory when taking into consideration the general financial depression of the entire country.

Societies have been organized during the past year in Bay, Marion, Osceola, Putnam and St. Johns counties.

All of which is respectfully submitted.

GRAHAM E. HENSON,
Secretary.

TREASURER'S REPORT.

FLORIDA MEDICAL ASSOCIATION.

1915.

Balance on hand, 1914.....	\$1,146.94
Dues collected from additional members secured during 1914-1915	174.50
Cash from Dr. J. H. Pierpont for Past President's button.....	5.00
Cash from A. F. Perry, Administrator Estate of Dr. J. D. Fernandez	745.87
Dues for ensuing year.....	1,200.00
	<hr/>
	\$3,272.31
By expense account as per vouchers	\$1,646.01
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Balance	\$1,626.30
	<hr/>
	\$3,272.31
All of which is respectfully submitted.	
GRAHAM E. HENSON,	
Treasurer.	

To the President and Members of the Florida Medical Association:

GENTLEMEN—I herewith submit my first annual report as Editor of THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION.

We have published eleven numbers from July, 1914, to May, 1915, both inclusive. I have distributed among the members a copy of the financial statement, which is attached to this report.

I think it might be said that THE JOURNAL, while less than a year old, is firmly established and on a good financial basis. I desire to call your attention to the fact that after deducting our present assets, consisting of furniture, accounts receivable and cash on hand, we have really only expended \$291.31 of the appropriation of \$800.00 made by the Association at our last annual meeting. At the present time we have advertising contracts varying in time from one month to a year, which, with the new

advertising contracts, we have every reason to believe we will secure, leaves little more to be desired from a financial point of view.

I wish, however, at this time to urge upon the members that we can not reasonably expect to secure advertising patronage if the firms advertising with us do not receive some benefit from the money spent with us. In a great many instances free samples and literature are offered and a simple request for these samples or literature is all that the advertiser requires to satisfy himself that the advertisement is well placed. While we are now issuing a journal that stands well with other state journals, having a similar or even a larger membership, there is no reason why we should not with the proper support of our members, very materially improve our present publication. I would urge that \$1.00 of the \$3.00 dues of the members be appropriated to the funds of THE JOURNAL and recommend that an amendment to the Constitution be made to cover this point. I wish to acknowledge my thanks to the Associate Editors for the valuable assistance given me, both in securing advertising patronage and in editing THE JOURNAL. I also desire to acknowledge my indebtedness to the Collaborators whose painstaking work throughout the entire year has resulted in maintaining a most attractive department in our publication.

All of which is respectfully submitted.

GRAHAM E. HENSON,
Secretary-Editor.

FINANCIAL STATEMENT OF THE JOURNAL OF

THE FLORIDA MEDICAL ASSOCIATION,

TO MAY 1, 1915.

Cash appropriation from Florida Medical Association	\$ 800.00
Cash rebate from Postal Authorities	49.01
Prepaid subscriptions	6.00
Earnings from advertisements:	
July	\$104.00
August	126.50
September	113.50

October	112.00
November	110.00
December	109.50
January	111.00
February	116.00
March	105.00
April	96.50— 1,104.00
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	\$1,959.01

Disbursements.

Expense (vouchers attached)	\$1,348.72
Commissions	42.46
Interest and Discount.	10.13—\$1,401.31
	<hr/>
	\$1,959.01

Assets.

Furniture	96.66
Accounts receivable ...	315.50
Cash on hand	145.54— 557.70
	<hr/>
	\$1,959.01

The Chair appointed Dr. Henry Hanson of Jacksonville and Dr. Thomas Truelsen of Tampa a committee to audit the accounts of the Treasurer and the Secretary-Editor. Upon motion duly seconded, the Association took a recess until 2 p. m.

The General Association was called to order at 2 p. m., by the President. In the absence of any member of the Scientific Committee, the President requested Dr. Truelsen of Tampa to take the chair and assume charge of the Scientific program.

The following papers were read and discussed:

“What Can Be Done for the Pellagra Situation in Florida,” H. Hanson, M. D., Jacksonville.

“Pellagra,” J. G. Dupuis, M. D., Lemon City.

“The Dermatological Aspect of Pellagra,” J. L. Kirby-Smith, M. D., Jacksonville, was read by title and ordered published in THE JOURNAL.

“Pellagra,” John Reeve, M. D., DeLand.

“A Case of Complete Absence of Vagina and Uterus,” E. W. Warren, M. D., Palatka.

“Uterus Duplex,” J. S. McEwan, M. D., Orlando.

“An Unpublished Circumcision Operation, with Manikin Illustrations,” J. Harris Pierpont, M. D., Pensacola.

“Remarks on the Surgery of Hemorrhoids,” Ralph Duffy, M. D., Tampa.

Upon motion the General Association took a recess until 8 p. m.

The General Association was called to order at 8 p. m., in the Auditorium of Stetson University, by Dr. John MacDiarmid of DeLand, Chairman of the Committee on Arrangements.

Dr. F. Clifton Moor, of Tallahassee, delivered the President’s Annual Address.

Dr. Gerry R. Holden delivered the Annual Oration, taking as his subject, “Surgery of Today: Its Ideals and Its Activities.”

After a musical program the members and their guests adjourned and attended a banquet at the Putnam Inn given by the members of the Volusia County Medical Society.

THURSDAY, MAY 13, 1915.

The General Association was called to order at 9 a. m. by J. C. Vinson, M. D., of Tampa, Chairman of the Scientific Committee, and the Scientific program resumed. The following papers were read and discussed:

“Tuberculosis, A Disease of Double Origin,” Hiram Byrd, M. D., Trilby.

“Some Observations on Presenility of the Eyes and the Effects of Light Upon the Eyes in this Latitude,” J. Frederick Walter, M. D., Daytona.

“The Progress of Intra-Nasal Surgery,” L. C. Ingram, M. D., DeLand.

“Direct Laryngoscopy and Tracheo-Bronchoscopy: Report of Cases,” H. M. Taylor, M. D., Jacksonville.

“Supraclavicular Brachial Plexus Block,” J. Knox Simpson, M. D., Jacksonville.

“The Surgical Treatment of Prolapse of the Uterus,” Thomas S. Field, M. D., Jacksonville.

"Spura-Pubic Prostatectomy," J. C. Vinson, M. D., Tampa.

"Relaxed Vaginal Outlet; Its Diagnosis and Treatment," Gerry R. Holden, M. D., F. A. C. S., Jacksonville.

The following papers were read by title and ordered published in *THE JOURNAL*:

"Tropical Abscess of the Liver, With Some Points on the Technique of Its Surgical Treatment," J. S. Helms, M. D., Tampa.

"Suggestions Concerning the Handling of Acute Appendicitis Before the Patient Reaches the Surgeon," Carey P. Rogers, M. D., F. A. C. S., Jacksonville.

"Ovarian Tumors," David Forster, M. D., New Smyrna.

"Appendicitis Complicating Pregnancy," Charles L. Jennings, M. D., Jacksonville.

The General Association upon motion adjourned.

The President called the House of Delegates to order at 11 a. m., and appointed the following committee for the purpose of drawing up certain proposed amendments to the constitution and by-laws of the Association, with instructions that they report back to the House of Delegates:

Dr. J. Harris Pierpont, Pensacola.

Dr. R. H. McGinnis, Jacksonville.

Dr. Graham E. Henson, Jacksonville.

Upon motion the House of Delegates adjourned and the General Association was called to order.

Nominations for the office of President were called for by the Chair.

Dr. Thomas Truelsen, of Tampa, placed in nomination the name of Dr. R. H. McGinnis, of Jacksonville. The nomination was seconded by Dr. J. Harris Pierpont, of Pensacola; Dr. Gerry R. Holden, of Jacksonville; Dr. H. K. DuBois, of Port Orange; Dr. Hiram Byrd, of Trilby; Dr. John MacDiarmid, of DeLand, and Dr. F. C. Moor, of Tallahassee.

It was moved and supported that nominations be declared closed and a ballot spread. Carried. The Chair appointed Drs. J. E.

Boyd, F. J. Walter, J. M. Masters and Hiram Byrd as tellers. The tellers reported the following vote: Dr. R. H. McGinnis, 52. Dr. McGinnis was declared unanimously elected President of the Florida Medical Association.

The Chair appointed Past Presidents John MacDiarmid, of DeLand, and J. Harris Pierpont, of Pensacola, as a committee to escort the newly elected President to the chair.

Dr. McGinnis, in a few well chosen words, thanked the Association for the honor conferred upon him, declaring that he would be untiring in his efforts for the welfare of the Association during the ensuing year, and asked for the hearty co-operation of every member.

Dr. J. Harris Pierpont, of Pensacola, presented the retiring President with a Past President's button.

The Chair called for nominations for first Vice-President.

Dr. J. Harris Pierpont nominated Dr. W. R. Stephens, of DeLand. Dr. Calvin D. Christ nominated Dr. John A. Simmons, of Arcadia. The nominations were declared closed and a ballot ordered spread. Dr. John A. Simmons received 28 votes and Dr. W. R. Stephens 26 votes. Dr. Simmons was declared elected First Vice-President.

Nominations for Second Vice-President were called for by the Chair. Dr. J. G. DuPuis, of Lemon City, placed in nomination Dr. Mary Freeman, of Perrine, the nomination was seconded by Dr. Hiram Byrd. There being no other nominations it was moved and supported that nominations be closed and the Secretary of the Association be authorized to cast the ballot of the Association for Dr. Mary Freeman. Carried. The Secretary cast the ballot and Dr. Freeman was declared elected Second Vice-President.

Nominations were called for the office of Third Vice-President. Dr. M. L. Crum, of Bowling Green, placed in nomination the name of Dr. J. H. Coffee, of Ft. Meade.

There being no further nominations it was moved and supported that nominations be declared closed and that the Secretary be authorized to cast the ballot of the Association for Dr. Coffee. Carried. The Secretary cast the ballot and Dr. Coffee was declared elected Third Vice-President.

Nominations for the office of Councillors in the fifth and eighth districts were called for.

Dr. Hiram Byrd placed in nomination Dr. E. Van Hood, of Ocala, for Councillor for the fifth district. There being no further nomination the Secretary was authorized to cast the ballot and Dr. E. Van Hood was declared elected Councillor for the fifth district.

Dr. Graham E. Henson placed in nomination Dr. Thomas Truelsen, of Tampa, as Councillor for the sixth district. There being no further nominations the Secretary was authorized to cast the ballot and Dr. Thomas Truelsen was declared elected as Councillor for the fifth district.

The next order of business was the selection of a meeting place for the next annual meeting. Dr. J. Harris Pierpont nominated Atlantic Beach for the place of holding the next annual meeting. Dr. John A. Simmons placed in nomination the city of Arcadia. This was seconded by Dr. G. R. Holden, of Jacksonville; Dr. C. D. Christ, of Orlando; Dr. E. W. Warren, of Palatka; Thomas Truelsen, of Tampa, and Dr. John MacDiarmid, of DeLand.

After considerable discussion, Dr. Pierpont withdrew his nomination. Dr. Hiram Byrd moved that the Secretary cast the ballot for Arcadia as the place of meeting in 1916. Carried. The Secretary cast the ballot and Arcadia was declared the Association's choice for the annual meeting in 1916.

The following Councillors' reports were read and ordered spread upon the minutes of the Association.

MAY 14, 1915.

To the President and Members of the Florida State Medical Association:

GENTLEMEN — As Councillor for the fourth district, I beg to offer the following report:

Conditions in general are favorable to organized medicine in this district. Societies exist in St. Johns and Duval counties. The Duval County Society is large, well organized and doing efficient work.

No societies exist in the other counties, and, on account of the small number of doctors in these counties, it is probably best not to organize them there. We have endeavored to get men from these counties to join the Duval County Society. This society already has active members from both Nassau and Clay counties. It is hoped that in the next year membership from these adjoining counties may be increased.

Respectfully submitted,

GERRY R. HOLDEN, M. D.,
Councillor Fourth District.

MAY 11, 1915.

Mr. President, and Members of the Florida Medical Association:

I am pleased to report a most satisfactory condition of the medical profession in the second district.

Quite, if not all eligible medical men are members of their respective county societies.

The Leon-Gadsden Society, embracing the counties of Leon, Gadsden and Franklin, have a large and enthusiastic membership.

The Medical Bill, reported by the Legislative Committee, passed the House yesterday, with an amendment, exempting the chiropraths and naturopaths, whatever these things may be, but I have the assurance from the friends of the bill in the Senate that this amendment will be knocked out, and we hope the bill passed as originally drafted.

Each member of the Association should write a personal letter to his Senator, urging him to kill this amendment, and support the original bill.

I regret my inability to be present, but am detained by a case in court. You have my best wishes for a most successful meeting.

Respectfully,

HENRY E. PALMER, M. D.,
Councillor Second District.

Mr. President and Members of the Florida Medical Association:

Of the five counties in the eighth councillor district, I regret to report that two remain unorganized. Baker and Levy counties have no county societies. And on account of the few physicians in these counties, and their distance from each other, it does not seem likely, from investigations I have made, that a county society could be successfully maintained in either county at present. In the case of Levy county several of her physicians hold membership in the Alachua County Medical Society and are valuable members.

Of the three counties in the district in which county societies are maintained, viz.: Alachua, Bradford and Putnam; I can speak enthusiastically of the Alachua County Society. This society, owing to the excellent work of its secretary, Dr. J. F. McKinstry, Jr., is thoroughly alive and active. Members frequently drive to Gainesville from distances of twenty and twenty-five miles to attend the meetings.

The Bradford County Society is maintaining its organization and holding regular meetings.

The Putnam County Society, I regret to report, has not been active, but Dr. Chandler, the secretary, writes me that he will make an effort to stir up more enthusiasm in the society.

Respectfully,

J. H. HODGES, M. D.,
Councillor Eighth District.

The Secretary read telegrams from Drs. C. L. Jennings, Ralph N. Greene, Oliver J. Miller, J. M. Irwin, and J. L. Kirby-Smith, expressing their regrets at being unable to attend the meeting.

Moved by Dr. L. B. Bouchelle and seconded that the Chair appoint a committee of three to draw up suitable resolutions, presenting the same to Dr. Otis Johnson, upon the fearful tragedy that had suddenly come into his life, and that the Secretary be instructed to send Dr. Johnson a telegram, expressing the grief and sympathy of the Association. Carried.

The Chair appointed Dr. Henry Hanson, of Jacksonville; Dr. Hiram Byrd, of Princeton, and Dr. J. G. DuPuis, of Orange City.

The Secretary read the following telegram:

"MOBILE, ALA., May 12, 1915.

"Florida State Medical Association, in Convention Assembled, DeLand, Fla.:

"The Southern Medical Association sends greetings. Hope that you are having a most successful meeting. May we not have a large number of Florida physicians with us at Dallas, Texas, in November. Come. A hearty welcome and a great meeting will await you.

"SEALE HARRIS,

"Secretary-Treasurer,

"Southern Medical Association."

Upon motion duly seconded, the message was ordered spread upon the minutes and the Secretary instructed to acknowledge and to thank Dr. Seale Harris for the cordial greetings. Carried.

Dr. J. K. Simpson, upon request, offered the following resolution:

"WHEREAS, It being known to the Florida Medical Association that there are hundreds of dependent epileptics within its borders, who are justly and humanely entitled to some beneficent form of State care, and,

"WHEREAS, Many States in the Union have created colonies or other special institutions for this class of dependents;

"*Resolved*, That this Association hereby recommends the founding by the State of a colony for this unfortunate class with a view to an ultimate population of eight hundred to one thousand, and that we endorse and urge the passage of the Epileptic Colony bill introduced at the instance of Dr. D. C. Main, of Welaka, now before the Legislature, and its executive approval after its passage.

"*Resolved*, further, That the Secretary send a copy of this resolution to the Governor and the presiding officers of the two Houses."

Upon motion duly seconded the resolution was adopted.

A general discussion concerning the Medical Practice Act pending in the Legislature followed. Upon motion duly seconded and carried, Dr. F. C. Moor was requested to send a telegram to Senator J. N. Fogarty, urging the early passage of the bill as amended in the House.

Moved by Dr. J. H. Pierpont and seconded that the Treasurer be authorized to pay the bills of the Committee on Legislation and Public Policy as compiled by Drs. F. C. Moor and E. W. Warren, and that the expenses of Dr. E. W. Warren in connection with his attendance at the Council of Medical Education held in Chicago, be ordered paid. Carried.

Upon motion duly seconded the Association adjourned.

The General Association was called to order at 2 p. m. by J. C. Vinson, M. D., Chairman of Scientific Work, and the Scientific program resumed.

H. P. Cole, M. D., of Mobile, Ala., delivered an illustrated lecture entitled, "Local Anesthesia in the Aged and Young; With Report of Cases."

Raymond C. Turck, M. D., F. A. C. S., of Jacksonville, delivered an illustrated lec-

ture entitled, "Bone and Joint Cases From the State Crippled Children's Service."

W. D. Spratling, M. D., of Baltimore, delivered an illustrated lecture entitled, "Biographical Illustrations of Epileptic Seizures."

The following papers were then read and discussed:

"The Tuberculosis Situation," J. B. Masters, M. D., Port Orange.

"Transmission of Malaria," Graham E. Henson, M. D., Jacksonville.

"Eclampsia and Its Treatment," Frederick J. Waas, M. D., Jacksonville.

Papers entitled, "Malaria Hematuria," by J. M. Irwin, M. D., of Crystal River, and "The Importance of the Motor Nerves in Affections of the Eye," by F. P. Hoover, M. D., of Jacksonville, were read by title and ordered published in *THE JOURNAL*.

Upon motion duly seconded the General Association adjourned.

The President called the House of Delegates to order at 8 p. m.

The Secretary read the following report of the special committee appointed to draw up certain proposed amendments to the Constitution and By-Laws of the Association:

"To the President and Members of the House of Delegates of the Florida Medical Association:

"GENTLEMEN—Your Committee appointed to draw up certain proposed amendments to the Constitution and By-Laws of the Association, have drawn up the following changes and unanimously recommend their adoption:

"That article six, reading:

"The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections, and for the organization of such councillor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies,'

"Be stricken from the Constitution.

"That section one, article eight, reading:

" 'The officers of this Association shall be a President, three Vice-Presidents, a Secretary-Treasurer and eight Councillors.'

"Be amended to read:

" 'The officers of this Association shall be a President, three Vice-Presidents, a Secretary-Treasurer and eleven Councillors.'

"That section three, article eight, reading:

" 'The officers of this Association shall be elected by the Association on the morning of the second day of the Annual Session and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such office who is not in attendance on that annual session and who has not been a member of the Association for two years,'

Be amended to read:

" 'The officers of this Association shall be elected by the Association on the morning of the second day of the Annual Session at 11 o'clock and any member shall be eligible to any office named in the preceding section, but no person shall be elected to such office who is not in attendance on that annual session (except the Councillors), and who has not been a member of the Association for two years.'

"That section two, chapter two, of the By-Laws, reading:

" 'Special sessions of either the Association or of the House of Delegates shall be called by the President at his discretion or upon petition of ten delegates,'

"Be amended to read:

" 'Special sessions of either the Association or of the House of Delegates may be called by the Executive Committee.'

"That section one, chapter five, reading:

" 'All elections shall be by secret ballot and a majority of the votes cast shall be necessary to elect,'

"Be amended to read:

" 'All elections shall be by secret ballot, unless there be but one nominee for the

office, when the Secretary is empowered to cast the ballot of the Association for the nominee. A majority of the votes cast shall be necessary to elect.'

"That the last sentence of section four, chapter six, reading:

" 'The amount of his salary shall be fixed by the House of Delegates,'

"Be amended to read:

" 'The amount of his salary shall be \$300.00 per annum.'

"That section one, chapter seven, reading:

" 'The Council shall hold daily meetings during the annual session of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Councillors. It shall meet on the last day of the annual session of the Association for re-organization and for the outlining of work for the ensuing year. At this meeting it shall elect a Chairman and Secretary and the latter shall keep a record of its proceedings. It shall through its Chairman make an annual report to the House of Delegates at such time as may be provided.'

"Be amended to read:

" 'The Executive Committee shall consist of five members, the President and Secretary being members ex-officio, the three remaining members to be appointed by the President at the first session of the Association. The Executive Committee shall hold daily meetings during the annual session of the Association and at such other time as necessity may require, subject to the call of the Chairman. It shall through its Chairman make an annual report to the House of Delegates at such time as may be provided.'

"That section three, chapter seven, reading:

" 'Collectively the Council shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether

in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General Meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a county society, upon which an appeal is taken from the decision of an individual councillor. Its decision in all such cases shall be final.'

"Be amended to read:

" 'The Executive Committee shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General Meeting must originate in the county society and shall be referred to the Executive Committee without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or of a county society upon which an appeal is taken from the decision of an individual councillor. Its decision in all such cases shall be final.'

"That section four, chapter seven be stricken from the By-Laws.

"That the following section be incorporated as section four, chapter eight:

" 'Section 4. The Executive Committee is empowered to conduct any business requiring attention in the interim between annual meetings.'

"That section one, chapter eight, reading:

" 'The Standing Committees shall be as follows:

" 'A Committee on Scientific Work.

" 'A Committee on Public Policy and Legislation.

" 'A Committee on Publication.

" 'A Committee on Nominations.

" 'A Committee on Medical Education.

" 'A Committee on Arrangements and such other Committees as may be necessary. Such Committees shall be elected by the House of Delegates unless otherwise provided.'

"Be amended to read:

" 'The Regular Committees shall be as follows:

" 'An Executive Committee.

" 'A Committee on Scientific Work.

" 'A Committee on Public Policy and Legislation.

" 'A Committee on Arrangement.

" 'These Committees shall be appointed by the President.'

"That section four, chapter eight, reading:

" 'The Committee on Publication shall consist of three members, of which the Secretary shall be one, and Chairman, and shall have referred to it all reports on scientific subjects, and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions, and any paper referred to it which may not be suitable for publication may be returned to the author. The Committee shall have authority to arrange for the publication and distribution of the Transactions. All papers read before the Association shall be its property.'

"Be amended to read:

" 'The Committee on Publication shall consist of the Secretary-Editor as Chairman and two other members to be appointed by the President and shall have referred to it all reports on scientific subjects and all scientific papers and discussions heard before the Association. It shall be empowered to curtail or abstract papers and discussions and any paper referred to it which may not be suitable for publication may be returned to the author. All papers read before the Association shall be its property. The Secretary-Editor shall receive an annual salary of three hundred dollars for his

services as Editor of the JOURNAL, this in addition to his salary as Secretary, provided that this appropriation be taken from the funds of the JOURNAL.'

"That section one, chapter nine, reading:

" 'An assessment of three dollars (\$3.00) per capita on the membership of the component societies is hereby made the annual dues of this Association. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association thirty days in advance of each Annual Session.'

"Be amended to read:

" 'An assessment of three dollars (\$3.00) per capita on the membership of the component societies is hereby made the annual dues of this Association. Of this amount one dollar (\$1.00) shall be set aside as a subscription for the JOURNAL. The Secretary of each county society shall forward its assessment together with its roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county to the Secretary of this Association thirty days in advance of each annual session.'

"(Signed) R. H. MCGINNIS, M. D.,

"J. HARRIS PIERPONT, M. D.,

"GRAHAM E. HENSON, M. D.,

"Committee."

Upon motion duly seconded and carried the report was accepted, the Committee discharged, and in accordance with the constitution the proposed amendments were laid upon the table to be brought up for consideration at the next annual meeting.

Doctor F. J. Walter of Daytona offered the following resolution:

"*Resolved*, That a copy of the rules and regulations relative to medical defense in alleged malpractice suits, presented and endorsed by the Volusia County Medical Society, be incorporated in the Constitution and By-Laws of this society."

In accordance with the Constitution the resolution was laid upon the table to be brought up for consideration at the next annual meeting.

It was moved by Doctor J. Harris Pierpont and seconded that the President appoint three members of the Association who, together with the President and Secretary, be designated as an Advisory Committee with the power to transact any business requiring the attention of the Association during the ensuing year. Carried.

It was moved by Doctor F. Clifton Moor and seconded that the House of Delegates nominate three, six or nine members of the Association, the list to be submitted to the Governor of the State with the request that he select from this number for appointment on the Medical Examining Board as consistent with the provisions of the New Medical Practice Act now pending in the Legislature.

Doctor J. S. McEwan offered an amendment which was duly seconded, providing that the Advisory Committee nominate ten men and send a list of the names to the Governor with the request that he select his appointees representing the regular school of medicine from this number. Carried.

*"To the President and Members of the
House of Delegates:*

"GENTLEMEN: Your Committee appointed to audit the accounts of the Treasurer and Secretary-Editor find that all accounts are correct.

"(Signed) HENRY HANSON, M. D.,

"THOMAS TRUELSEN, M. D.,

"Committee."

Doctor Thomas Truelsen read the following report of the Committee on Necrology:

"WHEREAS, during the past year it has pleased the Great Physician in his infinite wisdom to call to their rewards Drs. W. P. Lawrence of Tampa, E. F. McConnell of

DeLand and R. P. Daniel of Jacksonville, and,

"WHEREAS, in the death of these physicians our state has lost three most valuable citizens, and this Association three most esteemed members, be it,

"*Resolved*, That these resolutions be spread upon the minutes of the Association and a copy sent to the bereaved families.

"F. CLIFTON MOOR, M. D.

"THOMAS TRUELSEN, M. D.

"GASTON H. EDWARDS, M. D."

Doctor Graham E. Henson of Jacksonville moved that Doctor J. F. Walter of Daytona be declared an alternate of the House of Delegates of the American Medical Association. The motion was duly seconded and carried.

Doctor J. H. Pierpont moved that the railroad fare of the delegate to the American Medical Association be paid from the general funds of the Association. The motion was duly seconded and carried.

Doctor John MacDiarmid of DeLand read his report as Delegate to the American Medical Association for the year 1914.

Doctor J. A. Simmons of Arcadia moved the adoption of the following resolutions:

"WHEREAS, the Volusia County Medical Society has so ably, generously and pleasantly welcomed and entertained the members of the Florida Medical Association, and,

"WHEREAS, Stetson University, the Woman's Club, the Municipal and County officers and the press have all done so much to make our visit in DeLand one long to be remembered and enjoyed, therefore, be it,

"*Resolved*, That we tender our heartiest thanks and appreciation to the above mentioned organizations. Further be it,

"*Resolved*, That it is the sense of this Association that the pleasant surroundings have given us a better mental attitude in which to work out the good that is the purpose of our organization, and, be it further,

"*Resolved*, That a copy of these resolutions be given to the press and a copy spread upon the minutes of the Association."

A motion to adopt the above set of resolutions, being duly seconded, was carried by a rising vote.

Upon motion duly seconded the House of Delegates adjourned *sine die*.

The General Association was called to order at 8:45 p. m. by J. V. Vinson, M. D., and the Scientific Program resumed.

The following papers were read and discussed:

"Complications of Chronic Gonorrhœa," W. B. Bush, M. D., Lake City.

"Assisting Nature," Mary Freeman, M. D., Perrine.

"A Plea for Better Health Organization in the Smaller Municipalities of Florida," M. E. Heck, M. D., St. Augustine.

"Some Notes on Ameba," C. G. Roehr, M. D., Ft. Pierce.

"Indigestion," H. Marvin Smith, M. D., Jacksonville.

The following papers were read by title and ordered published in THE JOURNAL:

"Faulty Obstetrical Technique," W. M. Rowlett, M. D., Tampa.

"How the General Practitioner May Overcome Some of the Difficulties in the Treatment of Gonorrhœa in the Male," W. Marion Bevis, M. D., Tallahassee.

"Serotherapy," S. C. Kingsbury, M. D., Largo.

"Acute Glossitis, With Report of a Case," J. S. Helms, M. D., Tampa.

"The Significance of a Differential Blood Count," M. Price DeBoe, M. D., Cocoa.

"Vaccine and Serum Treatment of Disease," D. H. Simmons, M. D., DeFuniak Springs.

Upon motion duly seconded the General Association adjourned *sine die*.

The Journal of the Florida Medical Association

Owned and published by the Florida Medical Association.

Published monthly at St. Augustine and Jacksonville. Price, \$1.00 per year; 15 cents per single number.

Address Journal of the Florida Medical Association, St. Augustine, Florida, or 334 St. James Building, Jacksonville, Fla., U. S. A.

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Second District—Franklin, Gadsden, Jefferson, Leon, Liberty and Waukulla Counties: Henry E. Palmer, M. D., Tallahassee1917

Third District—Columbia, Hamilton, Madison, Lafayette, Suwanee and Taylor Counties: C. S. Brown, M. D., Live Oak1917

Fourth District—Duval, Clay, Nassau and St. Johns Counties: Gerry R. Holden, M. D., Jacksonville..1918

Fifth District—Citrus, Hernando, Lake, Marion and Sumter Counties: E. Van Hood, M. D., Ocala..1919

Sixth District—Hillsborough, Pasco and Pinellas Counties: Thomas Truelsen, M. D., Tampa.....1919

Seventh District—Brevard, Orange, Osceola, St. Lucie and Volusia Counties: David Forster, M. D., Hawks Park P. O., New Smyrna.....1918

Eighth District—Alachua, Baker, Bradford, Levy and Putnam Counties: J. H. Hodges, M. D., Gainesville1916

Ninth District—Calhoun, Holmes, Jackson and Washington Counties: J. S. McGeachy, M. D., Chipley, 1918

Tenth District—DeSoto, Lee, Manatee and Polk Counties: Y. E. Wright, M. D., Wauchula.....1916

Eleventh District—Dade, Monroe and Palm Beach Counties: W. R. Warren, M. D., Key West....1917

Next Meeting—Arcadia—May 10-12, 1916

OUR NEW PRESIDENT.

The selection of Dr. Robert H. McGinnis as President of the Florida Medical Association for the ensuing year has proven a source of gratification to his host of friends throughout the state and is a fitting tribute to a career punctuated by many other deserved honors.

Dr. McGinnis was born in Charlotte, N. C., in the year 1869, and received his earlier literary training in the high schools of that city. For a brief period he engaged in business in the city of his birth and entered on the study of medicine in 1893. He graduated from the University of Maryland in 1897 and served as interne in the University Hospital for one year after graduation. In 1898 he became associated with Dr. Jas. D. Love and located in Jacksonville, Fla., to pursue the practice of medicine. His association with Dr. Love still continues. Every distinction at the disposal of the physicians of Florida has at one time or another been conferred on Dr. McGinnis, and in addition he has received signal honors at the hands of the people of his community.

He served as Acting Assistant Surgeon U. S. M. H. and Public Health Service for a period of twelve years, resigning this position only two years ago. For two consecutive terms he was elected President of the Duval County Medical Society and during his entire professional career has been active in contributing to the upbuilding of this organization.

From the time of the organization of the Florida Life Insurance Company till the present he has served as its most efficient medical director. For a number of years he has been a member of the visiting staff of St. Luke's Hospital and following the retirement of Dr. R. P. Daniel he was chosen President of the visiting staff of this hospital. He is on the visiting staff of the Duval County Hospital and was the prime founder of a hospital for tuberculous patients in Duval county.

He has actively served as an Associate Editor of *THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION* since the appearance of our state publication.

His activity in behalf of philanthropic and charitable organizations has been one of the most conspicuous features of the life of Dr. McGinnis. He has been intimately connected with the workings of the Associated Charities, Infants' Welfare Society, Society for the Prevention of Tuberculosis, Duval County Milk Commission and other associations of like nature more or less well known. He is a fellow of the American Medical Association, a member of the National Association for the Study and Prevention of Tuberculosis, a member of the Southern Medical Association and, since 1913, has been a member of the council of this body. He is an internist of state-wide reputation and devotes especial attention in his practice to diseases of the chest. He has contributed numerous valuable papers to medical societies and journals; is a close student, a successful physician, and has gained and deserved the respect and admiration of his colleagues and the entire people of his community.

BETTER MEDICAL LEGISLATION OR NONE.

Before the recent legislature of this state the Committee on Medical Legislation and Public Policy of the Florida Medical Association presented an act defining and regulating the practice of medicine in Florida. The measure was one of the best documents covering the subject ever presented to our representatives for their consideration. Many concessions were made in the act by the regular profession to bring about a union of the different examining boards now existing in the state, and the manner in which a license of a derelict practitioner may be revoked. The act was drawn by competent and able attorneys and met the approval of most of the existing

boards and the profession these boards represent.

The measure met with consideration in the lower house of representatives and was favorably acted upon by this branch of the legislature with one objectionable amendment. Notwithstanding this amendment the senate committee having the bill before them saw fit to allow the measure to remain in committee and it was never presented to the senate. This senate committee was urged to present the bill to the senate in session. Why this action was taken by the committee we do not know.

It is apparent from this and past experiences that the medical profession of Florida must exert more effort directly and indirectly with each and every candidate for the legislature before and after his election, that needed—and sorely needed—legislation be secured for the benefit of the people of the state. Every member of the medical profession in the state who has the interests of the community, in which he practices his profession, woven into the innermost conscientiousness of his being, ought to see to it that men seeking honors in our legislature are in full knowledge of the desires of the profession and the needs of the public relative to medical legislation.

The medical profession, numbering some twelve to fourteen hundred, represent some of the best scientific talent in this country and if this body of educated, respected and respectable citizens will unite and favor just and reasonable regulation of the practice of medicine in this state there is no doubt but their wishes will be considered. Our efforts are not specially in our behalf. Every effort made to secure regulation has been in the interest of the public.

We do not know of a state in this country that now has more inadequate regulation of the treatment of "ills that flesh is heir to" than Florida. The multiple boards of examiners existing in the state are not conducive to the best interests of the people

who, at times, endeavor to secure aid when sick.

Anyone with no special training in the fundamental branches of medical science may, if he choose, practice medicine in this state. A graduate of a regular and reputable college of medicine, however, must stand a rigid and practical examination before a body of his confreres competent to judge of his qualifications to attend the sick and injured and afflicted. He must devote years to preliminary study and more years to medical study to enable him to secure a document entitling him to call himself a doctor of medicine. This preparation costs time, application and money, yet one who takes a few lessons in chiropractic and many other cults and pathies may exercise the right of competition of a scientific medical man.

The medical man must by "precept upon precept, example upon example," "in season and out of season," teach those with whom he comes in contact the facts, the accomplishments, the attainments, the honor that medicine has conferred upon humanity.

It behooves the regular profession to labor with zeal and enthusiasm, which his training and knowledge gives him, and not allow this Moloch of unscientific, quasi-scientific and charlatanry to foist its doctrine on the innocent, ignorant and credulous public.

OUR CANCER NUMBER.

Cancer is one of the most serious menaces to the life and health of the adult world today. It is therefore the duty of every practicing physician to lend his aid and co-operation to any organization or movement having for its purpose the solution of the problems involved in the situation, and the lessening of the ravages upon society of this great scourge.

Realizing the seriousness of the cancer problem, and the possibilities of its partial solution through educational means, there was organized The American Society for

the Control of Cancer, with the object of collecting statistics and disseminating knowledge concerning the early signs of the disease.

An active component unit of this organization is the Cancer Commission of the Pennsylvania State Medical Society. Through the efforts of its chairman, Dr. J. M. Wainwright, there will be published simultaneously over the country in July, special cancer issues of a large number of the leading medical journals. This should create a profound impression upon medical America and should emblazon upon the mind of every conscientious physician the burning questions: "Am I constantly on the watch for the early signs of cancer?" "Am I giving the best advice to my patients concerning precancerous lesions?"

THE JOURNAL OF THE FLORIDA MEDICAL ASSOCIATION is proud to have a part in this work and to add its hearty endorsement to the movement.

THE DeLAND MEETING.

A complete account of the official proceedings of the forty-second annual meeting of the Florida Medical Association appears in this issue of THE JOURNAL. It was an enthusiastic meeting and a most entertaining one. All who were able to attend expressed themselves as being well repaid. Nothing was left undone by the Committee on Arrangements for the comfort and entertainment of their guests and all agreed that the Volusia County Medical Society demonstrated their ability to entertain the Association.

ASSOCIATION NEWS.

The President has appointed the following regular committees:

COMMITTEE ON PUBLIC POLICY AND LEGISLATION.

F. C. Moor, M. D.; E. W. Warren, M. D.; J. H. Pierpont, M. D.

ADVISORY COMMITTEE.

J. D. Love, M. D.; G. R. Holden, M. D.,
F. A. C. S.; J. V. Freeman, M. D.

SCIENTIFIC COMMITTEE.

J. K. Simpson, M. D.; Thomas Truelsen,
M. D.; Frederick Waas, M. D.

Reviews from Current Literature

ARTHRITIS.

Zapffe, Fred C.: *Pathology and Treatment of Acute Infectious (Metastatic) Arthritis.* Surg., Gynec. and Obstet., 1915, Vol. XX, p. 198.

The writer emphasizes Murphy's statement that "every type of non-traumatic joint infection is a metastatic manifestation of a primary infection in some other part of the body." He states that "Disbelief in an 'idiopathic,' rheumatic, or dietetic arthritis is confirmed and strengthened by extended clinical observation. In the very nature of things, such a condition as an idiopathic non-traumatic arthritis is a pathologic possibility," and that "These arthritides are always of bacterial origin primarily, although bacteria may be and usually are absent from within the joint-cavity early in the disease process, a fact which has led to errors in treatment. For example, in cases of gonorrhœal arthritis, the gonococcus is not found in the joint-fluid or effusion in from 20 to 93 per cent of the cases, depending on the time which has elapsed between the appearance of the synovitis and the date of the aspiration."

In a fairly large number of these cases the original source of infection can not be easily determined, hence they have been termed idiopathic, rheumatic or dietetic arthritis. If, however, the patients are carefully examined and are subjected to the several serologic tests, the etiologic feature can be ascertained practically in all cases.

The writer states that in most cases joint infections can be connected or associated with "(1) trauma, or (2) exposure, as (a) wetting of the feet; (b) chilling of the surface of the body; (c) overexertion, and (d) fatigue. The joint involved has either been subjected to repeated traumas, slight in severity and not immediately productive of

subjective or objective symptoms, or the patient has sustained one severe trauma, which has left an indelible mark in the tissues of the joint traumatized, and has laid these tissues open to subsequent infection."

He particularly emphasizes the fact that "the infective micro-organisms have been present in the body before the trauma occurred; that they have lain dormant for a long or short period of time. In the traumatic infections we must distinguish between two types of cases: (a) the cases in which the infective micro-organisms are admitted directly to the surface of the synovial membrane or into the joint-cavity by penetration of the joint—a traumatic, direct infection arthritis; and (b) the cases in which the joint is not punctured or laid open, and in which the trauma merely serves to localize in the joint an infection which is already present elsewhere in the body—a metastatic hæmatogenous arthritis."

In the treatment of purely traumatic arthritis there are two indications: first, to prevent the destruction of the synovial membrane and, second, to remove the infectious material from the joint or to render it innocuous. This is done by first closing the joint capsule without drainage of the joint infected, injecting the joint with a two-per-cent solution of formaldehyde and glycerine, and applying Buck's extension. The joint may be aspirated and injected as often as the increase in joint tension or a rising temperature indicates.

The writer lays particular stress on the fact that in traumatic arthritis the joint cavity should not be drained since the exposure of any synovial joint-cavity to the air results in a destruction of the cells, with fibrous and possibly bony ankylosis.

In the treatment of metastatic arthritis, the writer quotes Murphy's plan of treatment and severely condemns joint drainage.

"Indications for treatment are (a) to relieve the patient of pain; (b) to prevent the destruction of tissue and subsequent deformity or ankylosis of the joint; (c) preserve the function of the joint."

The pain is the result of an increase in intra-articular tension. This may be relieved by aspiration. The joint may be sterilized by repeated injections of the formalin and glycerine mixture after aspiration, and deformity and ankylosis may be avoided by the application of the extension apparatus.

Zapffe states that extension should be applied immediately; that it may not always prevent ankylosis but that it always prevents deformity. Vaccine also should be employed, autogenous if possible to obtain, if not appropriate stock vaccines should be used.

R. C. T.

TENDON FIXATION.

Gallie, W. E.: Tendon Fixation for Deformity Resulting from Partial Paralysis. *Annals of Surgery*, 1915, Vol. LXI, p. 94.

The author reports the further development of his tendon fixation operation to correct deformities of the foot resulting from poliomyelitis. He has had satisfactory results in a series of fifty cases in which tendon fixation was done for various deformities resulting from complete paralysis of muscle groups. Technically the operation consists of transplanting a tendon or a part of a tendon into a groove or trough which is made in bone. After the tendon is isolated the periosteum of the selected bone is divided and a trough or groove made with a gouge. The tendon is laid in the trough thus prepared, sewn in place with kangaroo tendon and completely covered with periosteum. Union is usually firm in two months.

In the last case reported by the writer, the tendo Achilles was transplanted into the posterior surface of the tibia, the peronei tendons were transplanted into the os calcis

and the tibialis posticus was buried in the internal malleolus.

The writer states that with this method of tendon fixation a new operative field has been opened which will completely eliminate the silk ligament and reduce the necessity for braces in infantile paralysis to the minimum.

R. C. T.

UNUNITED FRACTURE.

Willey, A. G.: Deputy Surgeon-General Royal Navy, Ununited Fractures Treated by Long-Axial Drilling of the Fractured Bone-Ends. *British Journal of Surgery*, 1915, Vol. 2, p. 423.

The writer states that the reported method has been employed in many cases of long-standing nonunion and has not yet failed to produce an abundant callus. The Lane technique is employed; iodine is used. The operative field is not touched by the hand. The ununited ends of the bone are exposed and their terminal surfaces freshened by the removal of a very thin slice of callus or fibrous tissue. The medullary cavities are cleared of the plugs of callus or fibrous tissue and the bone ends are drilled in four or five places in a direction parallel to the long axis of the bone to a depth of from one to two inches. The drilled holes penetrate the indurated area and extend well into healthy vascular bone. The bone is then held in place by a Lane plate or suitable fixative.

The writer states that in every case rapid union has occurred, the only fault being that there may be an excess of callus.

R. C. T.

GASTRIC AND DUODENAL ULCER.

Sippy, Bertram W.: Medical Cure by an Efficient Removal of Gastric Juice Corrosion. *J. A. M. A.*, 1915, Vol. LXIV, p. 1625.

Sippy has gradually evolved a method of treating gastric and duodenal ulcer, of which he says that the results are far beyond early expectations. The treatment consists essentially in accurately protecting the ulcer from gastric juice corrosion until healing of the ulcer takes place.

Gastric and duodenal ulcers are probably caused by hematogenous bacterial invasion,

resulting in malnutrition and followed by necrosis from the peptic action of the gastric juice.

"The digestive action of the gastric juice is due to the solvent action of pepsin on albuminous substances that have been properly permeated by hydrochloric acid. Pepsin is practically inert in alkaline and neutral mediums. It acts slightly in the presence of a combined acid medium, but combined acids are incapable of preparing albumins properly for the action of pepsin. A free acid, such as hydrochloric acid, is required to permeate the albumin and prepare it for the full action of the peptic ferment. Pepsin exerts no appreciable solvent or digestive action on the raw and exposed surfaces of a gastric or duodenal ulcer in the absence of free hydrochloric acid.

The principle involved in the treatment advocated consists essentially in efficiently shielding the ulcer from the corrosive effect of the gastric juice. This is accomplished by maintaining an accurate neutralization of all free hydrochloric acid, thus rendering the digestive action of the gastric juice inert from 7 a. m. until about 10.30 p. m., or during the entire time that food and the accompanying secretion are present in the stomach. In addition it is accurately determined whether an excessive night secretion is present. If so, this is removed each night until the irritability of the gastric glands has subsided. Usually after three or four days of accurate control of free acidity the excessive night secretion disappears. Subsequently the normal quantity (about 10 c.c.) of gastric juice present in the stomach during the night is left undisturbed.

Briefly stated the treatment in outline presents itself about as follows: The patient remains in bed for from three to four weeks. A wide variety of soft and palatable foods may be given. The following plan of diet has been found most adaptable: Three ounces of a mixture of equal parts of milk and cream are given every hour from 7 a. m. until 7 p. m. After two or three days soft eggs and well-cooked cereals are

gradually added, until at the end of about ten days, the patient is receiving approximately the following nourishment: Three ounces of milk and cream mixture every hour from 7 a. m. until 7 p. m. In addition, three soft eggs, one at a time, and nine ounces of a cereal, three ounces at one feeding, may be given each day. The cereal is measured after it is prepared.

A large variety of soft and palatable foods may be used, such as jellies, marmalades, custards, creams, etc. The basis of the diet, however, should be milk, cream, eggs, cereals and vegetable purées.

The acidity is easily controlled by feeding every hour and giving alkalies midway between feedings. In addition to giving an alkaline powder midway between feedings, the powders are continued every half hour after the last feeding, until 10 o'clock. The powders used contain 10 grains each of heavy calcined magnesia and sodium bicarbonate, alternating with a powder containing 10 grains of bismuth subcarbonate and 20 or 30 grains of sodium bicarbonate midway between feedings.

Heavy calcined magnesia has approximately four times the neutralizing power of sodium bicarbonate, and since its action is much more prolonged than that of sodium bicarbonate it should be used between as many feedings as possible. An uncomfortable diarrhea usually prevents its exclusive use as a neutralizer.

In all cases of pyloric obstruction from duodenal and pyloric ulcer it has been found advisable to empty the stomach of all remaining food and secretion at about 10:30 p. m., thus removing the stimulus to an excessive night secretion. In most cases a short time after treatment is begun the stomach will be found empty at that time.

T. T.

TWILIGHT SLEEP.

Beach, Ralph M.: *Twilight Sleep; Report of 1,000 Cases.* The Amer. Jour. of Obs., 1915, Vol. LXXI, p. 727.

The author has analyzed one thousand cases collected in the United States. He

defines "twilight sleep" as an amnesia state, in which the patient seems to forget successive events in labor, a short time after they have occurred. She seems to be conscious of events at the time they occur and remembers incidents of the immediate preceding ten or fifteen minutes, but each successive event will, in its turn, be forgotten and the memories are not stored in the higher brain centers.

His technic is as follows: The patient must be definitely in labor, and, if a primipara, must have regular forcible pains at five-minute intervals with one or two fingers' dilatation, and thinning of the cervix. The patient is then isolated in a dark room and all sources of external irritation removed.

The first injection consists of morphine sulphate, gr. 1-6 to 1-8, and scopolabromine hydromide, gr. 1-130. At the end of one hour the second dose of scopolabromine hydromide, gr. 1-200, is given. Subsequent doses of scopolabromine hydromide depends upon the results of memory test. The keynote of success is an individualization of each patient, and a proper employment of the memory tests.

Beach considers that twilight sleep may be used in all cases of labor except under certain conditions. It is especially suitable in labors with a long first stage where dilatation is slow and also in the neurotic woman who is mentally and physically unfit to go through the ordeal of labor. The physically unfit woman is different from the above class and generally has some degree of uterine inertia and should not be subjected to the method.

As contraindications to its use, he mentions the following:

1. Primary uterine inertia is an absolute contraindication. If the patient is having weak, irregular pains at intervals of ten, fifteen or twenty minutes the method should not be used.

2. Marked pelvic contractions are a definite contraindication, as some operative procedure will be necessary.

3. Hemorrhages either from placenta previa, or accidental hemorrhages are contraindications.

4. A dying or dead baby should be a contraindication, not from a medical standpoint, but because the patient, if ignorant, will lay the stillbirth to the method employed.

5. The emergencies of labor, such as eclampsia, prolapsed cord, prolapsed arm, transverse presentation with ruptured membranes, etc., are all contraindications, as they are conditions which will demand some operative interference.

Beach enumerates the following advantages of the method:

1. The patient has practically a painless labor in about eighty-five per cent of all cases.

2. The patient does not have the subsequent nerve exhaustion that comes after a prolonged labor.

3. The milk secretions seem to be better.

4. We have fewer cervical lacerations.

5. Diminution in the number of high and median forceps operations.

6. Cardiac cases, even those with some break in compensation, go through the ordeal of labor with a minimum of nervous apprehension, and with the expenditure of less muscular energy.

7. Toxemic cases, even with increased blood pressure, go through labor with less likelihood of convulsions and the urinary output is not affected.

8. We will have more babies and better babies, as the women of the better class will not fear the ordeal of a painful labor.

The disadvantages are slight; the main difficulty is the prolongation of the second stage of labor. Restlessness in the second state is rather common also. The disadvantages ordinarily experienced usually are due to imperfect technic.

Twilight sleep is essentially a treatment to be carried out in the hospital, and success in it can only be obtained after careful study of the method.

G. R. H.

Subject Index

Abdominal Cesarean section, conservative.....	106	Legislation, organized medicine and.....	1
Abdominal pain in surgical diseases of the upper abdomen, the diagnostic value of.....	65	Malignant tumors of the jaws.....	76
American Public Health Association, the.....	145, 180	Materia medica.....	213
Anesthesia, intestinal resection without.....	228	Medical Examiners' meeting, Board of.....	211
Angina, Vincent's, with report of a case.....	110	Nervous and mental diseases, the role of pyorrhœa in the etiology of.....	232
Army Medical Corps examination.....	181	New and non-official remedies.....	32, 64, 96, 128, 158, 189, 222, 254, 352
Aseptic nursing.....	291	News items.....	30, 62, 95, 128, 158
Association news.....	30, 180, 378	Nursing, aseptic.....	291
Board of Medical Examiners' meeting.....	211	Obituaries:	
Bone transplantation.....	289	R. P. Daniel, M. D.....	315
Cancer, X-rays and their use in the treatment of.....	225	J. D. Fernandez, M. D.....	31
Cesarean section, conservative abdominal.....	106	W. P. Lawrence, M. D.....	210
Charities, conference of, new nationalism outlined at.....	345	J. C. L'Engle, M. D.....	120
Clinical Congress of Surgeons of North America.....	86	Oration.....	356
Compression of the spinal cord, misdiagnosed cases of.....	321	Oral cavity, syphilis of the.....	230
Conference of charities to discuss medical topics.....	279	Organized medicine and legislation.....	1
Contemporaries, from our.....	85, 117	Pathological vaginal discharges.....	165
County society news.....	179, 211, 245, 280	Pellagra conference.....	88
Correspondence.....	301	Pellagra in one family, report of six cases of.....	78
Curet, the abuse of the.....	45	Pelvic organs, acute inflammation of.....	161
Cystitis, a symptom.....	42	Physician and the public health, the family.....	97
Diagnosis and treatment of venereal ulcers.....	6	Plague in New Orleans.....	118
Diagnosis of pulmonary tuberculosis and the treatment of tuberculosis.....	133	Pregnancy, toxemias of.....	272
Diagnostic value of abdominal pain in surgical diseases of the upper abdomen, the.....	65	President's address.....	353
Directions.....	197	Preventive medicine.....	332
Drug addictions, the treatment of.....	201	Program, preliminary, forty-second annual meeting of the Florida Medical Association.....	338
Echinococcus cysts of the peritoneum, complicating acute appendicitis, a report of case of secondary multiple.....	73	Prostatic hypertrophy.....	113
Editorials:		Propaganda for reform.....	11, 53, 80, 114, 140, 175, 206, 235, 273, 303, 336, 360
Advertising policy, our.....	23	Public health, the family physician and the.....	97
Atlantic City meeting, the.....	23	Pyorrhœa in the etiology of nervous and mental diseases, the role of.....	232
American Public Health Association.....	82	Quackery, superstition and robbery, ancient and modern in the treatment of disease.....	33
Announcement.....	22	Remedies, should the physician dispense his own.....	172
Annual meeting, our.....	340	Renal tuberculosis.....	137
Cancer number, our.....	378	Reviews from current literature:	
Cancer in New Hampshire.....	343	Abdominal cutaneous reflexes, the.....	150
Cancer, the danger of delay in.....	240	Adrenalin and pituitrin, combined use of.....	58
County societies, the.....	84	Anesthesia, oil-ether colonic.....	91
Crotalin in epilepsy.....	178	Aperiosteal amputation.....	246
DeLand meeting, the.....	306, 378	Appendicitis, acute.....	316
Diagnosis, why physicians err in.....	342	Appendicitis.....	318
Endamebas and pus pockets about the teeth.....	278	Arthritis.....	379
Harrison narcotic law, the physician and the.....	311	Asiatic cholera.....	248
Health Boards and the taxpayers.....	313	Bile secretion.....	185
Legislation, suggested.....	306	Bladder irritability in women.....	286
Life insurance examinations.....	209	Blood platelets.....	221
Materia Medica often, consult your.....	207	Boas-Oppler bacillus.....	187
Medical defense fund.....	309	Bone graft, original surgical uses of.....	57
Medical journal advertising.....	145, 310	Bones and joints, diseases of.....	247
Medical legislation.....	178	Boric acid in the treatment of skin diseases.....	320
Medical legislation, an appeal for.....	377	Brachial neuritis.....	183
Medical legislation or none, better.....	22	Bromoderma of the leg.....	126
Medical licensure, a new departure in.....	244	Bronchitis, recurrent.....	186
Military surgery in the present war.....	242	Burns, the treatment of.....	282
Motherhood without fear.....	207	Cancer, early recognition of.....	24
New members.....	178	Cancer, radium in.....	24
News matter.....	55	Cancers, salicylic acid and zinc oxide plasters in the treatment of small skin.....	28
New York Tribune's campaign, the.....	340	Cancer, the results of operation for uterine.....	186
Organization.....	55	Cancer vaccine and anti-cancer globulins.....	182
Our correspondents.....	56	Carcinoma of the uterus, inoperable.....	185
Our new President.....	376	Cardiac stimulants, studies in.....	27
Patent medicine interests control the press, do.....	176	Casein-calcium milk.....	218
Poisonous fly destroyers.....	209	Cerebral spastic paralysis.....	346
Practical eugenics.....	84	Cesarean section, extraperitoneal.....	249
Progress of the times, the.....	83	Cod liver oils.....	288
Southern health exhibit.....	83	Congenital new growths of the skin and mucus membrane, treatment of.....	125
Southern Medical Association.....	116	Constipation and its treatment.....	25
Southern health exhibition and American Public Health Association meeting.....	117	Diarrhœa, infectious.....	350
State medical journal, do you want a.....	245	Diphtheria of the skin of unusual type.....	126
Summer resorts, the health of our.....	341	Diphtheria prophylaxis.....	152, 153
Tax, an unjust.....	276	Duodenal ulcer, diagnosis of.....	92
The Journal.....	54	Dysidrosis.....	126
Tuberculosis problem, the.....	144	Dysmenorrhœa.....	94
Tuberculosis treatment, U. S. Public Health Service report on a.....	241	Dysmenorrhœa, the atropin treatment of.....	249
Wine of Cardui activities.....	312	Eclampsia, Cesarean section for.....	25
Enemas, wise and otherwise.....	103	Ectopic gestation.....	349
Epilepsy, spinal, with report of case.....	294	Empyema.....	216
Epilepsy, two recoveries from.....	79	Epinephrin in urticaria.....	124
Epileptic child, the.....	204	Epididymitis, acute.....	247
Facial paralysis occurring in the treatment of syphilis.....	168	Erysipelas.....	217
Family physician and the public health, the.....	97	Femur, fracture of the neck of the.....	151
Filthy paper money.....	149	Food and foodstuffs, influence of.....	60
Florida Medical Association, proceedings of the Forty-first Annual Meeting of the.....	11	Fracture, repair after.....	248
Florida Medical Association, proceedings of the Forty-second Annual Meeting of the.....	362	Fracture, ununited.....	380
Glanders, report of a human case of.....	199	Gastric secretion, sugar and.....	187
Hepato-intestinal toxemia.....	296	Gas pains, relief of.....	183
Hookworm, malaria and other infectious diseases, medical inspection and education of school children the most probable solution of.....	49	Gastric and duodenal ulcer.....	380
Infant stools, the character of.....	198	Goiter, surgery in.....	92
Inflammation of the pelvic organs, acute.....	161	Gonorrhœa, complement fixation in.....	127
Intestinal resection without anesthesia.....	228	Gunshot wounds.....	284
Jaws, malignant tumors of the.....	76	Hay fever.....	286
Karell-Kur, the.....	3	Herpes zoster.....	152
Laboratory diagnosis of tuberculosis.....	139	Infants, acid intoxication in.....	27
Larva migrans.....	326	Infant feeding, boiled milk in.....	219
Larynx, sand-spur in the, its removal, with report of two cases.....	9	Infants, institutional treatment of.....	250
		Influenza.....	219
		Iodine in surgery.....	122

Subject Index—Continued

Leprosy, attempted cultures in a case of, unsuccessful.....	29	Syphilis, diagnostic methods in.....	125
Leprosy, modern vs. Biblical.....	61	Syphilis in colored canal laborers.....	155
Leucorrhea, the pathology and treatment of chronic.....	59	Tetanus.....	184, 319
Leucocyte count, differential.....	156	Tendon fixation.....	380
Lung, decortication of the.....	216	Tonsils, the.....	154
Lupus, trichloroacetic acid treatment of.....	155	Trifacial foramina.....	183
Measles.....	250	Tuberculin test.....	287
Military first aid in military surgery.....	122	Tuberculosis, lingual.....	351
Military surgery.....	286	Tuberculosis of the male genito-urinary system.....	93
Neurthrosis.....	347	Twilight sleep.....	217, 381
Neosalvarsan, intradural injections of.....	61	Typhoid fever in children.....	124
Ninhydrin reaction, the.....	123	Ulcers, treatment of chronic leg.....	251
Ovarian tumors in pregnancy.....	319	Vaccine therapy, external.....	29
Padgett's disease.....	93	Vaginitis.....	157
Pellagra, change of climate and high altitude in the treatment of.....	29	Verucose dermatitis.....	126
Pellagra, diagnosed before cutaneous symptoms appear.....	61	Vomiting, recurrent.....	154
Pituitrin, cases of diabetes insipidus, treated with.....	58	War surgery.....	121
Placental extract, the oxytocic effect of.....	319	Wasserman, observations on the.....	60
Plaque, the continuous metastatic nature of the spread of.....	61	Wasserman test, the.....	251
Poliomyelitis, an attempt to transmit.....	127	Whooping cough, silver nitrate solution in the treatment of.....	28
Polypoid chondro-fibroma.....	123	Yaws in the United States.....	288
Pott's fracture, with complications, a discussion of.....	56	Sandspur in the larynx, its removal, with report of two cases.....	9
Pott's paralysis.....	246	Sanitary management, general.....	257
Prostatectomy, transvesical.....	347	Southern Medical Association, the.....	181
Psoriasis, autogenous serum in the treatment of.....	220	Spinal cord, compressions of the, misdiagnosed cases of.....	321
Pyloric stenosis in infants, medical aspects of the treatment of.....	28	Spinal epilepsy with report of a case.....	294
Pyorrhea.....	283	State legislature, members of the.....	191
Rabies, serodiagnosis of.....	288	Surgery of today: its ideals and its activities.....	356
Radium and X-ray in the treatment of skin diseases and cancers, comparison of.....	156	Surgical and conservative treatment of joint tuberculosis.....	129
Radium, the use of.....	153	Syphilis, facial paralysis occurring in the treatment of.....	168
Radium therapy.....	349	Syphilis of the innocent.....	193
Rectal alimentation.....	95	Syphilis of the oral cavity.....	230
Retrodplacement of the uterus, following confinement.....	59	Toxemia, hepato-intestinal.....	296
Ringworm infection of the genito-crural region.....	320	Toxemia; some points on etiology and symptoms with deductions.....	202
Salvarsan and neosalvarsan, injections of concentrated solutions of.....	29	Toxemias of pregnancy.....	272
Salvarsan and neosalvarsan.....	220	Trachoma.....	329
Salvarsan in the treatment of syphilis.....	251	Tuberculosis, laboratory diagnosis of.....	139
Scarlet fever.....	184, 352	Tuberculosis, renal.....	137
Shick reaction, the.....	124	Tuberculosis, surgical and conservative treatment of joint.....	129
Skin grafts.....	214, 284	Tuberculosis, the diagnosis of pulmonary; and the treatment of tuberculosis.....	133
Spine, fracture and dislocation of the.....	215	Tuberculosis, to interest physicians and nurses in.....	344
Spirochæta, pallida, second infection with.....	126	Tumors of the jaws, malignant.....	76
Sporotrichosis.....	155, 320	Vaginal discharges, pathological.....	165
Streptococic arthritis.....	184	Veneral ulcers, diagnosis and treatment of.....	6
Syphilis, continental methods of treating.....	351	Vincent's angina, with report of a case.....	110
		Vomiting, an unsuccessful attempt to provoke.....	171
		X-rays and their use in the treatment of cancer.....	225

Authors' Index

BENTON, G. H.....	332	McEWAN, J. S.....	113
BICKERSTAFF, J. H.....	296	McGINNIS, R. H.....	133
BIRD, U. S.....	197	McKAY, W. G.....	110
BOYD, JOHN E.....	65	McRAE, JOHN D.....	225
CHRIST, CALVIN D.....	9	NILES, GEORGE M.....	103
DAVIS, J. C.....	49	PAGE, W. C.....	198
DEY, WALTER P.....	6, 230	PAYNE, W. C.....	289
DOZIER, HENRY C.....	326	PEEK, L. A.....	199
DUFFY, RALPH.....	129	PIERPONT, J. HARRIS.....	1
FIELD, T. S.....	165	PORTER, JOSEPH Y.....	257
FREEMAN, A. H.....	172	RANDOLPH, J. H.....	232
HANSON, H.....	139	ROEHR, C. G.....	202
HARRIS, L. J.....	291	SIMPSON, J. KNOX.....	45, 137
HELMS, JOHN S.....	73	SPRATLING, W. P.....	79, 294
HERLONG, M. B.....	201	TERRY, C. E.....	97
HOLDEN, G. R.....	161, 356	TURCK, RAYMOND C.....	76, 228
HOOVER, F. P.....	329	TRUELSEN, THOMAS.....	3
JENNINGS, CHARLES I.....	106	VINSON, J. C.....	42
KIRBY-SMITH, J. L.....	78, 168, 193	WAAS, F. J.....	272
MAIN, D. C.....	79, 204	WALTER, FREDERICK J.....	171
MOOR, F. C.....	353	WARREN, W. R.....	33
		WILLIAMS, TOM A.....	321

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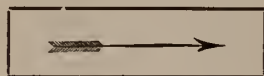
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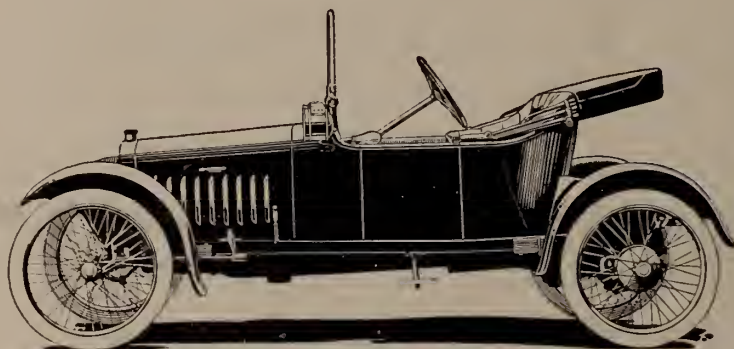
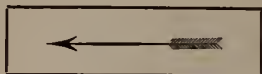
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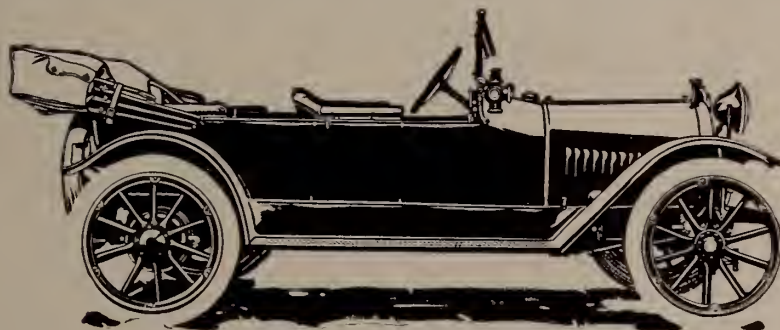
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CONTENTS

ORIGINAL ARTICLES	EDITORIALS
Quackery, Superstition and Robbery, Ancient and Modern, in the Treatment of Disease, W. R. Warren, M. D., Key West..... 33	THE JOURNAL 51
Cystitis—A Symptom. Report of Cases, J. C. Vinson, M. D., Tampa..... 42	Organization 55
The Abuse of the Curet, J. Knox Simpson, M. D., Jacksonville 45	News Matter 55
Medical Inspection and Education of School Children the Most Probable Solution of Hookworm, Malaria and Other Infectious Diseases, J. C. Davis, M. D., Quincy 49	Our Correspondents 56
Propaganda for Reform 53	
	REVIEW OF CURRENT LITERATURE
	A Discussion of Pott's Fracture with Complications 56
	Original Surgical Uses of the Bone Graft... 57
	Combined Use of Adrenalin and Pituitrin... 58

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CONTENTS—Continued

REVIEW OF CURRENT LITERATURE—Con.

Case of Diabetes Insipidus Treated with Pituitrin	53
The Pathology and Treatment of Chronic Leucorrhœa	59
Retrodplacement of the Uterus following Confinement	59
Influence of Food and Foodstuffs.....	60
Observations on the Wasserman.....	60
Pellagra Diagnosed before Cutaneous Symptoms Appear	61
Intradural Injections of Neosalvarsan.....	61
Modern Leprosy vs. Biblical Leprosy.....	61
The Continuous Metastatic Nature of the Spread of Plague	61
News Items	62
New and Non-Official Remedies.....	64

INDEX TO ADVERTISEMENTS

Atlanta Medical College.....	i
Atkinson Tire and Supply Co.....	vii
Claude Nolan—Cadillac Motor Cars.....	iv
College of Medicine of Tulane University.....	xix
Dr. Morse's Sanatorium.....	vi
Drs. Petty and Wallace's Sanatorium.....	vii
Florida National Bank	v
Florida Life Insurance Company.....	xv
Groover-Stewart Drug Co.....	ii
G. H. Sherman.....	vii
Hess & Slager.....	xi
Hotel Seminole.....	xiii
James & Paxson.....	xv
John A. Cunningham.....	viii
Jacksonville Gas Co.....	vii
Lexington-Howard Auto Co.....	iii
Mellin's Food.....	xiv
Medical College of the State of South Carolina.....	xviii
Officers of the County Medical Societies.....	xvi
Parke, Davis & Co.....	back cover
Record Co.....	viii
St. Luke's Hospital—Dr. Stuart McGuire.....	vi
Stuart-Bernstein Co.....	x
School of Medicine—University of Alabama.....	xviii
Surgical Supply Co.....	xiv
Sinkler-Price Co.—Hupmobile Auto Co.....	xiii
Taylor's Drug Store.....	ix
The Bond & Bours Co.....	iv
The Heard National Bank.....	v
The Atlantic National Bank.....	v
The C. V. Mosby Co.....	x
The H. and W. B. Drew Co.....	xi
The Florida Tuberculosis Sanatorium.....	xii
The Bettes Pharmacy.....	xv
University of Georgia—Medical Department.....	xviii
Vanderbilt University.....	xvi

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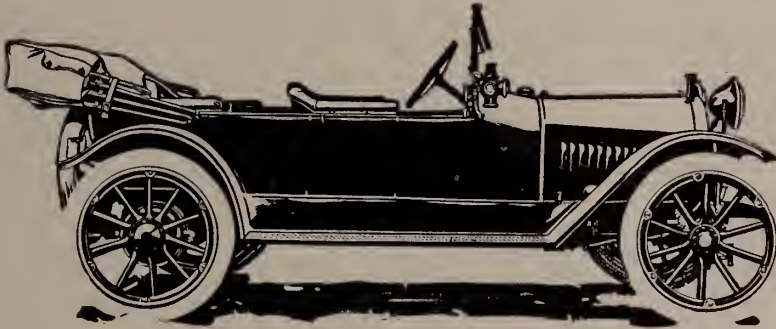
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CONTENTS

ORIGINAL ARTICLES

- The Diagnostic Value of Abdominal Pain in Surgical Diseases of the Upper Abdomen, John E. Boyd, M. D., Jacksonville..... 63
- A Report of Case of Secondary Multiple Echinococcus Cysts of the Peritoneum, Complicating Acute Appendicitis, John S. Helms, M. D., Tampa..... 73
- Malignant Tumors of the Jaws, Raymond C. Turek, M. D., Jacksonville..... 76
- Report of Six Cases of Pellagra in One Family, J. L. Kirby-Smith, M. D., Jacksonville..... 78
- Two Recoveries from Epilepsy, W. P. Spratling, M. D., and D. C. Main, M. D., Welaka..... 79
- Propaganda for Reform..... 80

EDITORIALS

- The American Public Health Association..... 82
- The Progress of the Times..... 83
- Southern Health Exhibit..... 83
- The County Societies..... 84
- Practical Eugenics..... 84
- From Our Contemporaries..... 85
- Clinical Congress of Surgeons of North America..... 86
- Pellagra Conference..... 88
- Reviews From Current Literature..... 91
- News Items..... 95
- New and Non-Official Remedies..... 96

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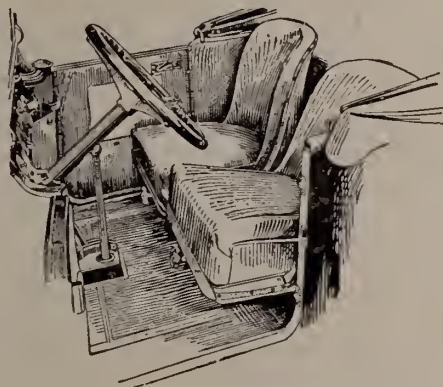
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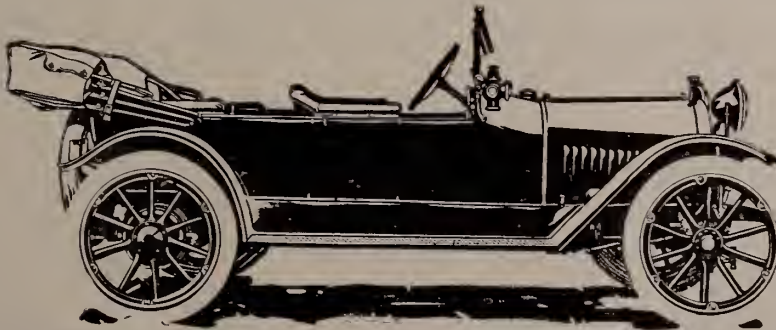
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|---|-----|--|-----|
| The Family Physician and the Public Health,
C. E. Terry, M. D., Jacksonville..... | 97 | The Southern Medical Association..... | 116 |
| Enemas, Wise and Otherwise, George M.
Niles, M. D., Atlanta, Ga..... | 103 | The Southern Health Exhibition and Amer-
ican Public Health Association Meeting.. | 117 |
| Conservative Abdominal Cæsarian Section,
Charles L. Jennings, M. D., Jacksonville. | 106 | From Our Contemporaries..... | 117 |
| Vincent's Angina, With Report of a Case,
W. G. McKay, M. D., Jacksonville..... | 110 | The Plague in New Orleans..... | 118 |
| Prostatic Hypertrophy, J. S. McEwan, M. D.,
Orlando, Fla. | 113 | Obituary—John Clandius L'Engle, M. D.... | 120 |
| Propaganda for Reform..... | 114 | Reviews from Current Literature..... | 121 |
| | | News Items | 128 |
| | | New and Non-official Remedies..... | 128 |

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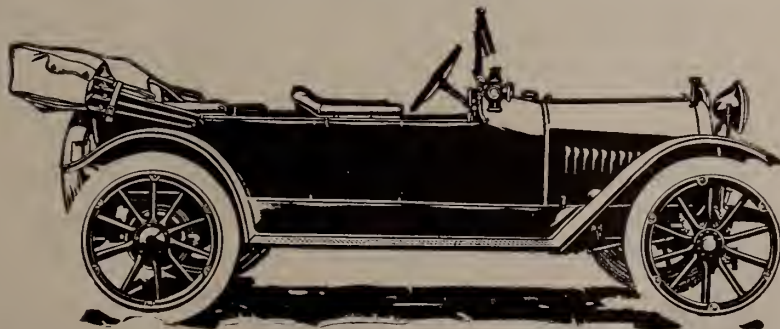
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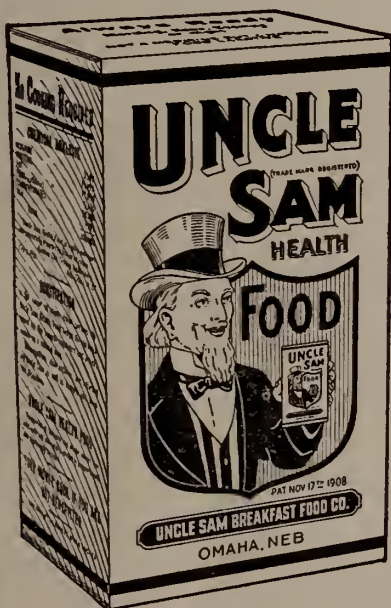
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CONTENTS

ORIGINAL ARTICLES

Surgical and Conservative Treatment of Joint
Tuberculosis, Ralph Duffy, A. B., M. D.,
Tampa 129

The Diagnosis of Pulmonary Tuberculosis and
the Treatment of Tuberculosis, Robert H.
McGinnis, M. D., Jacksonville..... 133

Renal Tuberculosis, J. Knox Simpson, M. D.,
Jacksonville 137

Laboratory Diagnosis of Tuberculosis, Henry
Hanson, M. D., Jacksonville..... 139

Propaganda for Reform..... 140

EDITORIALS

The Tuberculosis Problem..... 144

Medical Journal Advertising..... 145

Erratum 145

The American Public Health Association.... 145

Filthy Paper Money..... 149

Reviews from Current Literature..... 150

News Items 158

New and Non-official Remedies..... 158

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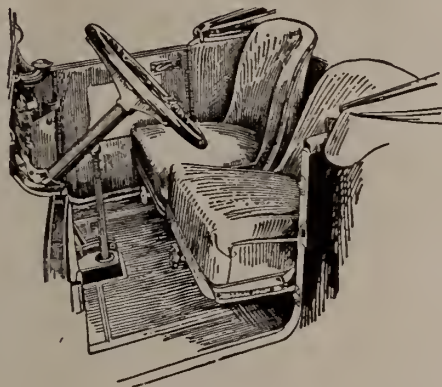
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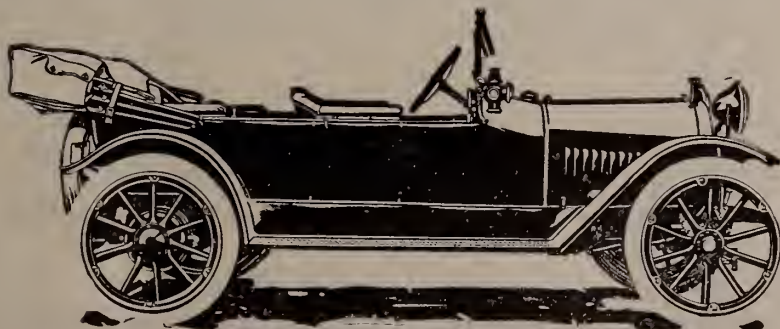
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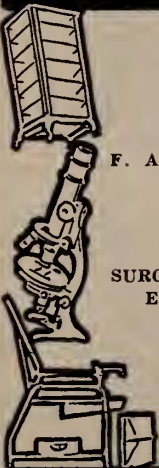
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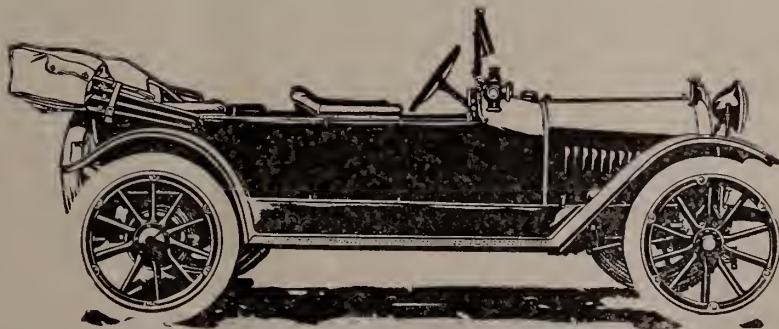
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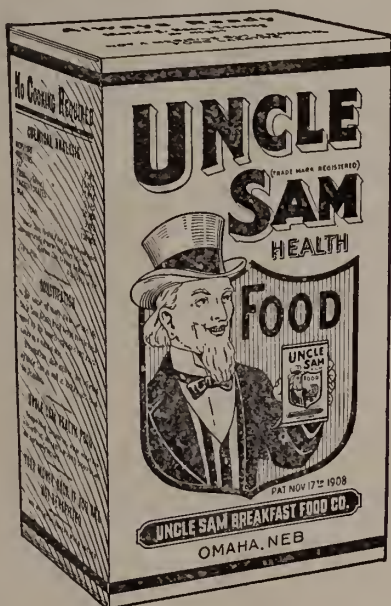
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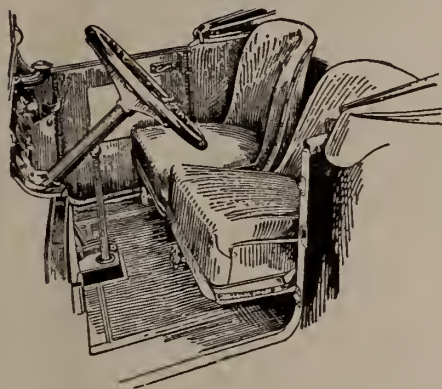
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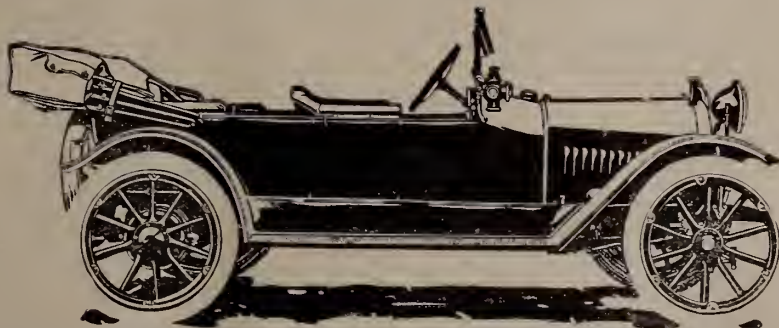
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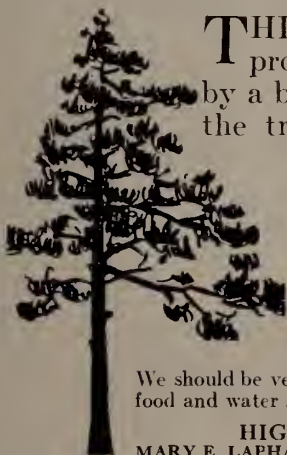
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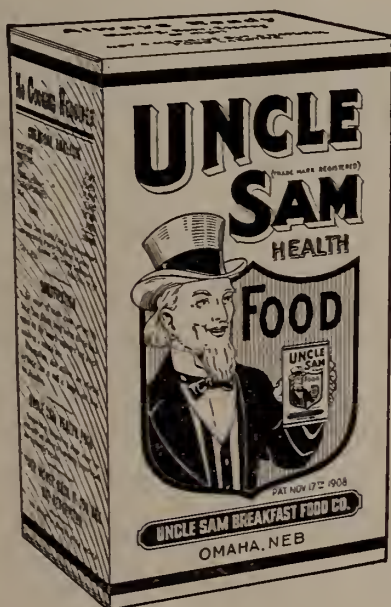
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CONTENTS

ORIGINAL ARTICLES	EDITORIALS
X-Rays and Their Use in the Treatment of Cancer, John D. McRae, M. D., Tampa..... 225	The Danger of Delay in Cancer..... 240
Intestinal Resection Without Anæsthesia, Raymond C. Turck, M. D., F. A. C. S., Jacksonville 228	U. S. Public Health Service Report on a Tuberculosis Treatment 241
Syphilis of the Oral Cavity, Walter P. Dey, M. D., Jacksonville 230	Military Surgery in the Present War..... 242
The Role of Pyorrhœa in the Etiology of Nervous and Mental Diseases, James H. Randolph, M. D., Jacksonville..... 232	A New Departure in Medical Licensure..... 244
Propaganda for Reform..... 235	Do You Want a State Medical Journal?..... 245
	County Society News..... 245

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Contents—Continued

REVIEWS FROM CURRENT LITERATURE.	The Atropin Treatment of Dysmenorrhoea....	249
Aperiosteal Amputation	Institutional Treatment of Infants.....	250
Pott's Paralysis	Measles	250
Diseases of the Bones and Joints.....	Treatment of Chronic Leg Ulcers.....	251
Acute Epididymitis	Salvarsan in the Treatment of Syphilis.....	251
Repair After Fracture.....	The Wasserman Test	251
Asiatic Cholera		
Extraperitoneal Cesarean Section.....	New and Nonofficial Remedies.....	254

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3mo.	4 lb.	6				
3mo.	5 lb.	9				
3mo.	6 lb.	12				
4mo.	7 lb.	15				
4mo.	8 lb.	18				
5mo.	9 lb.	21				
5mo.	10 lb.	24				
6mo.	11 lb.	27				
6mo.	12 lb.	30				
7mo.	13 lb.	33				
7mo.	14 lb.	36				
8mo.	15 lb.	39				
8mo.	16 lb.	42				
9mo.	17 lb.	45				
9mo.	18 lb.	48				
10mo.	19 lb.	51				
10mo.	20 lb.	54				
11mo.	21 lb.	57				
11mo.	22 lb.	60				
12mo.	23 lb.	63				
12mo.	24 lb.	66				
12mo.	25 lb.	69				
12mo.	26 lb.	72				
12mo.	27 lb.	75				
12mo.	28 lb.	78				
12mo.	29 lb.	81				
12mo.	30 lb.	84				
12mo.	31 lb.	87				
12mo.	32 lb.	90				
12mo.	33 lb.	93				
12mo.	34 lb.	96				
12mo.	35 lb.	99				
12mo.	36 lb.	102				
12mo.	37 lb.	105				
12mo.	38 lb.	108				
12mo.	39 lb.	111				
12mo.	40 lb.	114				
12mo.	41 lb.	117				
12mo.	42 lb.	120				
12mo.	43 lb.	123				
12mo.	44 lb.	126				
12mo.	45 lb.	129				
12mo.	46 lb.	132				
12mo.	47 lb.	135				
12mo.	48 lb.	138				
12mo.	49 lb.	141				
12mo.	50 lb.	144				
12mo.	51 lb.	147				
12mo.	52 lb.	150				
12mo.	53 lb.	153				
12mo.	54 lb.	156				
12mo.	55 lb.	159				
12mo.	56 lb.	162				
12mo.	57 lb.	165				
12mo.	58 lb.	168				
12mo.	59 lb.	171				
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12mo.	67 lb.	195				
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12mo.	69 lb.	201				
12mo.	70 lb.	204				
12mo.	71 lb.	207				
12mo.	72 lb.	210				
12mo.	73 lb.	213				
12mo.	74 lb.	216				
12mo.	75 lb.	219				
12mo.	76 lb.	222				
12mo.	77 lb.	225				
12mo.	78 lb.	228				
12mo.	79 lb.	231				
12mo.	80 lb.	234				
12mo.	81 lb.	237				
12mo.	82 lb.	240				
12mo.	83 lb.	243				
12mo.	84 lb.	246				
12mo.	85 lb.	249				
12mo.	86 lb.	252				
12mo.	87 lb.	255				
12mo.	88 lb.	258				
12mo.	89 lb.	261				
12mo.	90 lb.	264				
12mo.	91 lb.	267				
12mo.	92 lb.	270				
12mo.	93 lb.	273				
12mo.	94 lb.	276				
12mo.	95 lb.	279				
12mo.	96 lb.	282				
12mo.	97 lb.	285				
12mo.	98 lb.	288				
12mo.	99 lb.	291				
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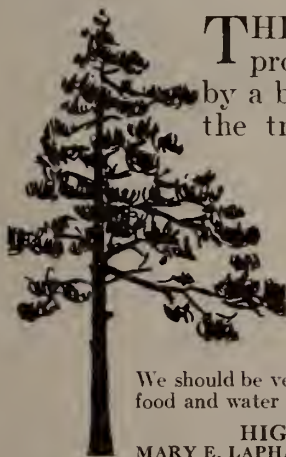
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CONTENTS

ORIGINAL ARTICLES

General Sanitary Management, Joseph Y. Porter, M. D., Jacksonville.....	257	Conference of Charities to Discuss Medical Topics	279
Toxæmias of Pregnancy, Frederick J. Waas, M. D., Jacksonville, Fla.....	272	County Society News.....	280
Propaganda for Reform.....	273	REVIEWS FROM CURRENT LITERATURE.	
EDITORIALS		The Treatment of Burns.....	282
An Unjust Tax.....	276	Pyorrhea	283
Endamebas and Pus Pockets About the Teeth.	278	Skin Grafts	284
		Gunshot Wounds	284

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Contents—Continued

REVIEWS FROM CURRENT LITERATURE.	Tuberculin Test	287
Military Surgery	Cod Liver Oils	288
Hay Fever	Yaws in the United States.....	288
Bladder Irritability in Women.....	Serodiagnosis of Rabies.....	288

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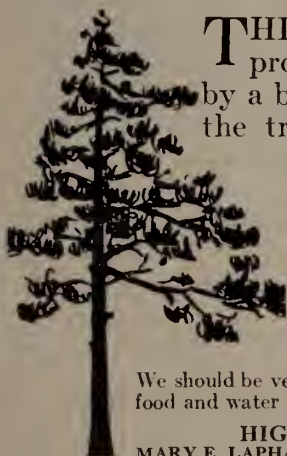
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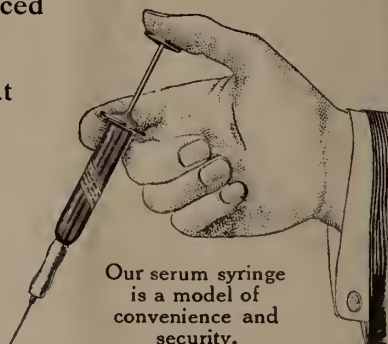
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No. 10

Jacksonville, Florida, April, 1915

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CONTENTS

ORIGINAL ARTICLES

Bone Transplantation, W. C. Payne, M. D., Pensacola	289
Aseptic Nursing, L. J. Harris, R. N., Jacksonville	291
Spinal Epilepsy with Report of Case, William P. Spratling, M. D., Welaka	294
Hepato-Intestinal Toxemia, J. H. Bickerstaff, M. D., Pensacola	296

Correspondence	301
Propaganda for Reform	303

EDITORIALS

The DeLand Meeting	306
Suggested Legislation	306
Medical Defense Fund	309
Medical Journal Advertising	310

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Contents—Continued

EDITORIALS—Continued

The Physician and the Harrison Narcotic Law 311

Wine of Cardui Activities..... 312

Health Boards and the Taxpayers..... 313

Obituary—Richard P. Daniel, M. D., Jacksonville 315

REVIEWS FROM CURRENT LITERATURE.

Acute Appendicitis 316

Appendicitis 318

Tetanus 319

The Oxytocic Effect of Placental Extract.... 319

Ovarian Tumors in Pregnancy..... 319

Ringworm Infection of the Genito-Crural Region 320

Boric Acid in Treatment of Skin Diseases.... 320

Sporotrichosis 320

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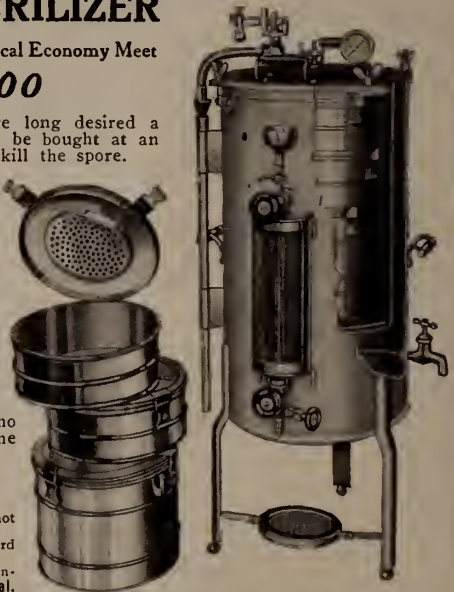
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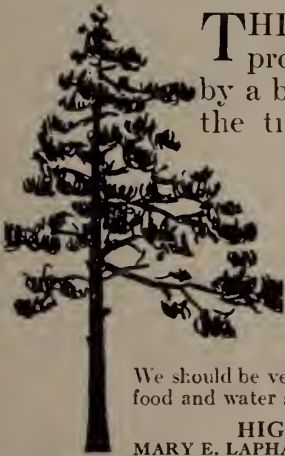
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No. 11

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CONTENTS

ORIGINAL ARTICLES

Misdiagnosed Cases of Compression of the
Spinal Cord, Tom A. Williams, M. B., C.
M. Edin., Washington, D. C. 321

Larva Migrans, Henry C. Dozier, M. D., Ocala 326

Trachoma, F. P. Hoover, M. D., Jacksonville. 329

Preventive Medicine, G. H. Benton, M. D.,
Miami 332

Propaganda for Reform..... 336

Preliminary Program, Forty-Second Annual
Meeting of the Florida Medical Associa-
tion 338

EDITORIALS

Our Annual Meeting 340

The New York Tribune's Campaign..... 340

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Contents—Continued

EDITORIALS—Continued

The Health of Our Summer Resorts.....	341
Why Physicians Err in Diagnosis.....	342
Cancer in New Hampshire.....	343

To Interest Physicians and Nurses in Tuberculosis	344
---	-----

New Nationalism Outlined at Conference of Charities	345
---	-----

REVIEWS FROM CURRENT LITERATURE.

Cerebral Spastic Paralysis.....	346
Nearthrosis	347
Transvesical Prostatectomy	347
Ectopic Gestation	349
Radium Therapy	349
Infectious Diarrhoea	350
Continental Methods of Treating Syphilis...	351
Lingual Tuberculosis	351
Scarlet Fever	352

New and Nonofficial Remedies.....	352
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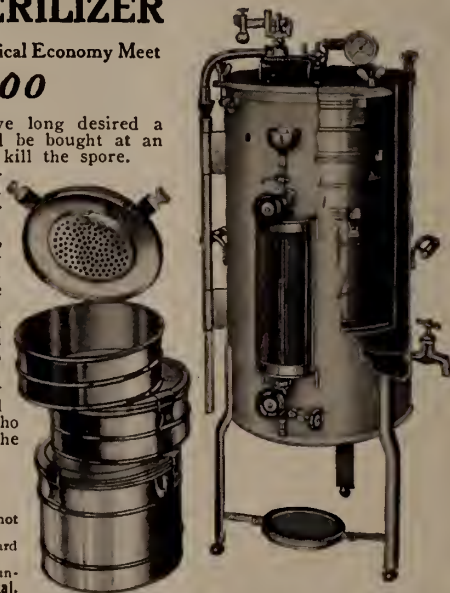
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VOLUME I
No. 12

St. Augustine and Jacksonville, Fla., June, 1915

Yearly Subscription, \$1.00
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CONTENTS

ORIGINAL ARTICLES

President's Address, F. Clifton Moor, M. D., Tallahassee	353
Surgery of Today: Its Ideals and Its Activ- ities, Gerry R. Holden, M. D., F. A. C. S., Jacksonville	356
Propaganda for Reform	360
Proceedings of the Forty-second Annual Meet- ing of the Florida Medical Association..	362

EDITORIALS

Our New President.....	376
Better Medical Legislation or None.....	377
Our Cancer Number.....	378
The DeLand Meeting	378
Association News	378
REVIEWS FROM CURRENT LITERATURE	
Arthritis	379
Tendon Fixation	380
Ununited Fracture	380
Gastric and Duodenal Ulcer.....	380
Twilight Sleep	381

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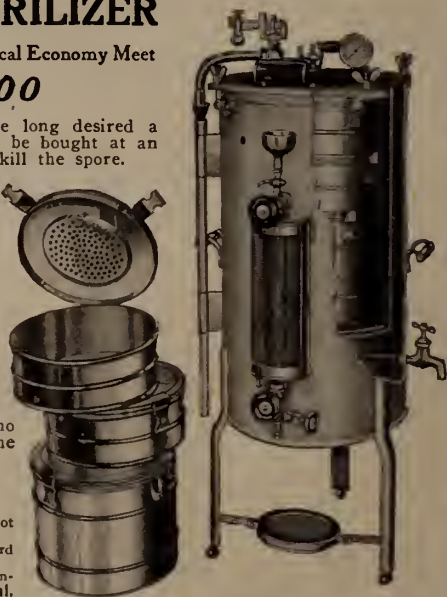
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IN THE border to this page, the natural beard of the wheat has been combined with the blossom of the flax to indicate the two chief ingredients—wheat and flax—in **UNCLE SAM BREAKFAST FOOD**.

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FIRST:—To provide a wholesome food for the young and old which will have a high nutritive value.

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SECOND:—To supply a palatable food having a natural laxative quality.

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When flaxseed is added to the wheat as in **UNCLE SAM BREAKFAST FOOD**, we have together the nutritious proteins of the wheat which are the lumber out of which tissue is constructed, and the natural cathartic principle of the flax which removes the putrefying intestinal contents. The basis upon which this food was originated will be at once appreciated by the medical profession.

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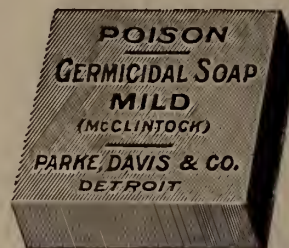
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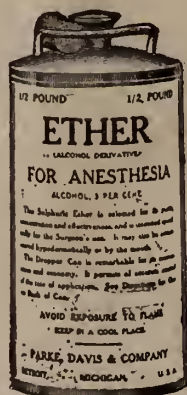
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